BOARD OF ESTIMATE AND CONTRACT

ROME, NEW YORK 13440-5815

Joseph R. Fusco, Jr., Mayor
John Mazzaferro, President of Common Council
Frank Tallarino, Commissioner of Public Works
Timothy A. Benedict, Corporation Counsel
David C. Nolan, Treasurer

BOARD OF ESTIMATE AND CONTRACT MEETING **FEBRUARY 26, 2015**
REGULAR SESSION **3:00PM**

1. **CALLING THE ROLL OF MEMBERS BY THE CLERK**

2. **READING OF THE MINUTES OF THE PRECEDING SESSION**
   (Motion in order that the reading of the minutes of the proceeding sessions be dispensed with and that they be approved.)

3. **COMMUNICATIONS**

4. **PUBLIC SPEAKERS**

5. **REPORT OF DEPARTMENT HEADS**

6. **RESOLUTIONS**

   RES. NO. 55
   A

   AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS FOR THE 2015 CDBG NEIGHBORHOOD PEDESTRIAN CONNECTIVITY & SAFETY IMPROVEMENTS PROJECT. Tallarino

   RES. NO. 56
   B

   AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS FOR THE SUPPLY OF ONE (1) 2015 OR NEWER FORD OR CHEVY 1 TON 4X4 REG CAB & CHASSIS TRUCK FOR WATER POLLUTION CONTROL FACILITY. Piekarski

RES. NO. 57
C

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS FOR THE SUPPLY OF TWO (2) ROTORK ACTUATORS. Piekarski

RES. NO. 58
D

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS TO PROVIDE BATHROOM/SHOWER ROOM RENOVATION AT THE CITY OF ROME FIRE DEPARTMENT. Piekarski

RES. NO. 59
E

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS FOR SUPPLY OF ONE (1) USED MINIVAN (2010 OR NEWER). Piekarski

RES. NO. 60
F

AUTHORIZING THE MAYOR OF THE CITY OF ROME TO ENTER INTO REHABILITATION AGREEMENT WITH REGARD TO PROPERTY LOCATED AT 301 LAWRENCE STREET, NEW YORK. Domenico

RES. NO. 61
G

AUTHORIZING THE MAYOR OF THE CITY OF ROME TO ENTER INTO AN AGREEMENT WITH BROWN & BROWN CONSULTING. Nolan

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RES. NO. 63
I

AUTHORIZING THE MAYOR TO ENTER INTO AN AGREEMENT WITH AN AUDITING FIRM OR CERTIFIED PUBLIC ACCOUNTANT FOR 2015. Nolan

RES. NO. 64
J

AUTHORIZING THE MAYOR OF THE CITY OF ROME TOENTER INTO AN AGREEMENT WITH WAGEWORKS, INC. (AN AFFILIATE OF AFLAC). Nolan

RES. NO. 65
K

AUTHORIZING AN EXTENSION OF AN AGREEMENT WITH R&S COMPLETE TEXTILE (ROBISON & SMITH, INC.) TO PROVIDE PROFESSIONAL LINEN/LAUNDY SERVICES FOR CITY OF ROME FIRE DEPARTMENT. Piekarski

7. TABLED RESOLUTION

RES. NO. 46
D

AUTHORIZING THE MAYOR OF THE CITY OF ROME TO ENTER INTO AMENDMENT NO. 1 WITH GHD CONSULTING ENGINEERS FOR ADDITIONAL PROFESSIONAL ENGINEERING SERVICES RELATED TO THE CITY OF ROME RAW WATER TUNNEL REHABILITATION PROJECT. Tallarino

8. ADJOURNMENT

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 55

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS FOR THE 2015 CDBG NEIGHBORHOOD PEDESTRIAN CONNECTIVITY & SAFETY IMPROVEMENTS PROJECT

By _____:

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, New York, that the City Clerk is hereby authorized and directed to advertise for bids for the 2015 CDBG Neighborhood Pedestrian Connectivity & Safety Improvements Project, and

BE IT FURTHER RESOLVED, that such bids shall be returned to the Office of the City Clerk, 1st floor, Rome City Hall, no later than 3:00 p.m. on March 26, 2015, said bids to be opened in the Common Council Chambers, 2nd floor, Rome City Hall, at 3:00 p.m. on the same date, and

BE IT FURTHER RESOLVED, that the City of Rome reserves the right to reject any and all bids deemed not to be in the best interests of the City of Rome.

Seconded by_____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 56

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS
FOR THE SUPPLY OF ONE (1) 2015 OR NEWER FORD OR CHEVY 1 TON
4X4 REG CAB & CHASSIS TRUCK FOR WATER POLLUTION CONTROL FACILITY

By _____:

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, New York, that the City Clerk is hereby authorized and directed to advertise for bids for the supply of one (1) 2015 or Newer Ford or Chevy 1 Ton 4X4 Reg Cab & Chassis truck for Water Pollution Control Facility, and

BE IT FURTHER RESOLVED, that such bids shall be returned to the Office of the City Clerk, 1st floor, Rome City Hall, no later than 3:00 p.m. on March 12, 2015, said bids to be opened in the Common Council Chambers, 2nd floor, Rome City Hall, at 3:00 p.m. on the same date, and

BE IT FURTHER RESOLVED, that the City of Rome reserves the right to reject any and all bids deemed not to be in the best interests of the City of Rome.

Seconded by_____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 57

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS
FOR THE SUPPLY OF TWO (2) ROTORK ACTUATORS

By _____:

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, New York, that the City Clerk is hereby authorized and directed to advertise for bids for the supply of two (2) Rotork Actuators, per specs and standardization for Water Filtration Plant Boyd Dam, and

BE IT FURTHER RESOLVED, that such bids shall be returned to the Office of the City Clerk, 1st floor, Rome City Hall, no later than 3:00 p.m. on March 13, 2015 (due to crucial time constraint of project), said bids to be opened in the Common Council Chambers, 2nd floor, Rome City Hall, at

3:00 p.m. on the same date, and

BE IT FURTHER RESOLVED, that the City of Rome reserves the right to reject any and all bids deemed not to be in the best interests of the City of Rome.

Seconded by_____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 58

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS TO PROVIDE BATHROOM/SHOWER ROOM RENOVATION AT THE CITY OF ROME FIRE DEPARTMENT

By _____:

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, New York, that the City Clerk is hereby authorized and directed to advertise for bids to provide bathroom/shower renovation at the City of Rome Fire Department, and

BE IT FURTHER RESOLVED, that such bids shall be returned to the Office of the City Clerk, 1st floor, Rome City Hall, no later than 3:00 p.m. on March 26, 2015 said bids to be opened in the Common Council Chambers, 2nd floor, Rome City Hall, at 3:00 p.m. on the same date, and

BE IT FURTHER RESOLVED, that the City of Rome reserves the right to reject any and all bids deemed not to be in the best interests of the City of Rome.

Seconded by_____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 59

AUTHORIZING THE CITY CLERK TO ADVERTISE FOR BIDS FOR SUPPLY OF ONE (1) USED MINIVAN (2010 OR NEWER)

By _____:

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, New York, that the City Clerk is hereby authorized and directed to advertise for bids for the supply of one (1) used minivan (2010 or newer), and

BE IT FURTHER RESOLVED, that such bids shall be returned to the Office of the City Clerk, 1st floor, Rome City Hall, no later than 3:00 p.m. on March 12, 2015 said bids to be opened in the Common Council Chambers, 2nd floor, Rome City Hall, at 3:00 p.m. on the same date, and

BE IT FURTHER RESOLVED, that the City of Rome reserves the right to reject any and all bids deemed not to be in the best interests of the City of Rome.

Seconded by_____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 60

AUTHORIZING THE MAYOR OF THE CITY OF ROME TO ENTER INTO REHABILITATION AGREEMENT WITH REGARD TO PROPERTY LOCATED AT 301 LAWRENCE STREET, NEW YORK.

By _____:

WHEREAS, Rome City Charter Title A, Section 33 states that a sale of real estate shall not be valid or take effect unless approved by the Board of Estimate and Contract of the City of Rome; and

WHEREAS, a certain city owned parcel of land is in need of rehabilitation and the City desires to sell and convey said real property to buyer, and obtain a written guarantee from the buyer that he will perform and accomplish the necessary rehabilitation within the agreed upon time frame of six (6) months from the date said rehabilitation agreement is executed; now, therefore,

BE IT RESOLVED, that the Mayor of the City of Rome is authorized to enter into a Rehabilitation Agreement, prepared and approved by the City of Rome Corporation Counsel and the City of Rome Codes Enforcement Officer, for property located at 301 Lawrence Street (Tax Map No. 242.066-0002-037) with Ranjit Singh Lubana for the rehabilitation of said property located at 301 Lawrence Street (Tax Map No. 242.066-0002-037); and

BE IT FURTHER RESOLVED, by the Board of Estimate and Contract of the City of Rome that it approves and confirms the sale and conveyance of the property located at 301 Lawrence Street (Tax Map No. 242.066-0002-037), in consideration of the performance of a Rehabilitation Agreement for said property, and for the sum of Six Thousand Five Hundred and 00/100 Dollars ($6,500.00), said conveyance to take place following the contingencies hereinafter set forth; and

BE IT FURTHER RESOLVED, that this authorization is contingent upon the execution by the buyer of the Rehabilitation Agreement within thirty days of the adoption of this Resolution; and

BE IT FURTHER RESOLVED, that subsequent to the execution of the Rehabilitation Agreement, this authorization is further contingent upon the granting of a written certification by the City of Rome Codes Enforcement Officer, stating that he has inspected the properties and that the buyer has completed all necessary rehabilitation in the time period required by the agreement; and

BE IT FURTHER RESOLVED, that upon receipt of the written certification from the Codes Enforcement Officer, the Mayor is hereby authorized to execute any and all deeds or other documents necessary to complete the transfer of title of said parcel of land; and

BE IT FURTHER RESOLVED, that this authorization is contingent upon the buyer having completed this transaction by rendering payment in full to the City of Rome within forty-five (45) days following receipt and review of copies of the proposed transfer documents pursuant to this sale; and

BE IT FURTHER RESOLVED, that the real property shall at no point in time be sold, transferred, titled or conveyed to any person who was a record owner and/or mortgagor of the property within the five (5) year period immediately preceding the date on which the property was taken by the City of Rome for non-payment of taxes. If such prohibited conveyance shall be made by any party in the succeeding chain of title, then immediately thereon (a) this conveyance shall become null and void to the buyer, his successors and/or assigns, and (b) the title to the above premises shall revert back to the City of Rome.

Seconded by _____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 61

AUTHORIZING THE MAYOR OF THE CITY OF ROME TO
ENTER INTO AN AGREEMENT WITH BROWN & BROWN CONSULTING

By _____;

WHEREAS, David Nolan, Treasurer for the City of Rome, has recommended that the City of Rome, New York, retain the professional services of Brown & Brown Consulting, to provide GASB 45 actuarial services for the year ended December 31, 2014; now, therefore,

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, that the Mayor of the City of Rome is hereby authorized to enter into an agreement with Brown & Brown Consulting, relative to preparing the annual actuarial evaluation of the City of Rome's post-employment benefits as required by the Governmental Accounting Standards Board, at a total cost not to exceed $2,200.00, pursuant to their attached proposal which by this reference is made a part of this Resolution.

Seconded by _____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

Brown & Brown Consulting

February 18, 2015

Mr. David C. Nolan
Treasurer
City of Rome
198 North Washington Street
Rome, NY 13440

Re: Proposal for GASB 45 Actuarial Services

Dear Dave:

This letter details the services and fees to perform GASB 45 actuarial services for 2014 year end reporting with respect to the retiree welfare plan sponsored by the City of Rome (the "City").

UNDERSTANDING OF SERVICES

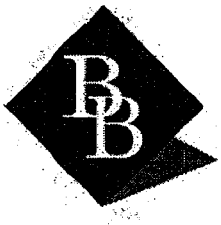
The City sponsors a retiree welfare plan that provides postretirement medical, hospitalization, dental, vision, and life insurance benefits to eligible retirees. The City has multiple divisions, with different eligibility requirements and different benefits. The City requires costs to be broken out by each division. The Plan covers approximately 300 full-time active employees and 350 retirees. As of December 31, 2014, there have been no material changes in the covered plan participants or the level of plan benefits since January 1, 2014.

The City needs an interim roll forward actuarial valuation of the retiree welfare plan in accordance with GASB 45 for its December 31, 2014 fiscal year end reporting requirements.

SCOPE OF SERVICES

We will perform a roll forward of our January 1, 2014 actuarial valuation of the City's postemployment benefits based on employer contributions for retiree healthcare and life insurance coverage and payroll information provided by the City and assuming no actuarial gains or losses for the 2014 fiscal year.

Our report will detail the actuarial liabilities and provide the GASB 45 financial statement disclosure information for the fiscal year ended December 31, 2014. The source data, plan provisions, actuarial methods and assumptions will be the same as those detailed in our January 1, 2014 actuarial valuation.



Brown & Brown Consulting

FEES AND TIMING

Our charge to complete the roll forward actuarial valuation report that will provide the necessary information to complete the City's financial statement audit with respect to the Plan will be based on our time charges using the hourly rates below, and is guaranteed not to exceed $2,200.

Our fees quoted are contingent on the work remaining in the normal scope of the assignment, as it exists at the present time. If there is a significant expansion of the services required of us, such as analyzing the cost impact of changing the eligibility requirements, changing the level of benefits provided, changing the retiree contributions, etc., we reserve the right to adjust the fee cap, but the adjustment would be mutually agreed upon in advance. Projects outside of the scope of services stated above will be billed based on time and expense using the hourly rates below or a fixed-fee can be quoted if project parameters are clearly defined.

Senior Actuary - $325
Consulting Actuary - $285
Actuary - $235
Senior Analyst - $200
Analyst - $185
Junior Analyst - $165

We expect to provide our valuation report within three business days of receipt of the information required for the valuation.

SERVICE TEAM

The primary consultants will be William J. Patti, EA, MAAA and Curt R. Evans, FSA, EA, and they will be assisted by Corey Deck.

If you have any questions or need further clarification of anything in this letter, please feel free to contact me to discuss.

We look forward to hearing from you. If you agree with the terms of the services and fees, please sign and return.

Respectfully,

Curt Evans
Senior Consulting Actuary

APPROVED:

_____
City of Rome

By: _____

Title: _____

Date: _____

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 62

AUTHORIZING THE MAYOR OF THE CITY OF ROME TO ENTER INTO AN AGREEMENT WITH PROACT, INC.

By _____;

WHEREAS, David Nolan, Treasurer for the City of Rome, has recommended that the City of Rome, New York, retain the professional services of ProAct, Inc., relative to providing claims processing services for prescription drugs offered under the City of Rome, health care plans to its employees and retirees, the term of this agreement is from January 1, 2014 through December 31, 2016 and shall continue for another year, unless terminated by either party prior to December 31, 2016; now, therefore,

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, that the Mayor of the City of Rome is hereby authorized to enter into an agreement with ProAct, Inc., relative to providing claims processing services for prescription drugs offered under the City of Rome, health care plans to its employees and retirees, pursuant to their attached proposal which by this reference is made a part of this Resolution.

Seconded by _____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

PROACT, INC. SERVICE AGREEMENT

with

CITY of ROME

ProAct, Inc.
6333 Route 298
East Syracuse, NY 13057
(315) 413-7780

SERVICE AGREEMENT

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PROACT, INC. SERVICE AGREEMENT

THIS SERVICE AGREEMENT (hereinafter referred to as the "Agreement") is entered into this first day of January, 2014, between ProAct, Inc., a New York corporation with offices located at 6333 Route 298, East Syracuse, New York 13057 (hereinafter referred to as "ProAct"), and the City of Rome, with offices located at 198 North Washington Street, Rome, New York 13440 (hereinafter referred to as "Plan Sponsor").

WHEREAS, Plan Sponsor is a municipality organized under the laws of the State of New York and desires to offer a pharmacy prescription drug benefit plan providing for the dispensing of prescription drugs and other covered products to Plan Participants; and

WHEREAS, Plan Sponsor desires to hereby engage ProAct to perform services relating to prescription drug claim processing, eligibility verification, mail service pharmacy and preparation of drug management and utilization reports required by Plan Sponsor; and

WHEREAS, ProAct is qualified to perform the matters referred to hereunder and is willing to do so upon and subject to the terms and conditions hereof.

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, Plan Sponsor and ProAct hereby agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Average Wholesale Price

The term "Average Wholesale Price" shall mean the average wholesale price of a prescription drug or medication dispensed as set forth in the current price list updated no less than weekly in recognized sources such as Medi-Span or First Data Bank, including its supplements, or other nationally recognized pricing source as determined by ProAct in its sole discretion. The applicable Average Wholesale Price ("AWP") for prescriptions dispensed at retail and mail services pharmacies shall be based on the actual package size submitted. In the event of any material change in the method used to determine AWP by First DataBank or Medi-Span, or should First DataBank and Medi-Span not continue to publish AWP pricing, the parties agree to modify the pricing hereunder to maintain the parties' respective economic position under this Agreement as of the Effective Date such that the aggregate net price of a product is the same as before such change or discontinuance occurred.

1.2 Benefit Plan

The term "Benefit Plan" shall mean Plan Sponsor's plan document covering prescription drug benefits, including Claims processing parameters and other information specifying healthcare coverage for Plan Participants, as those parameters currently exist or may be amended in the future. Plan Sponsor will provide ProAct with certain information relating to such Benefit Plans ("Benefit Plan Information"), as required in Section 4.2.

1.3 Claims

The term "Claims" shall mean those prescription drug claims processed through ProAct's on-line claims adjudication system or otherwise transmitted or processed in accordance with the terms of this Agreement in connection with a Benefit Plan.

1.4 Copayment

The term "Copayment" shall mean such amounts as are required to be paid to Participating Pharmacies by Plan Participants according to the Benefit Plan Information provided by Plan Sponsor, which may be a deductible, a percentage of the prescription price or a fixed charge.

1.5 Dispensing Fee

The term "Dispensing Fee" shall mean the amount established by agreement between Plan Sponsor and ProAct on the date of execution hereof, and modified thereafter by agreement between ProAct and Plan Sponsor, as the standard Participating Pharmacy fee for filling a single prescription.

1.6 Effective Date

The term "Effective Date" shall mean the date upon which this Agreement shall be effective. The Effective Date is the first day of January 2014

1.7 ERISA

The term "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

1.8 Formulary

The term "Formulary" shall mean the list of prescription drugs and medications identified by ProAct for routine use and which will be dispensed through Participating Pharmacies to Plan Participants.

1.9 HIPAA

The term "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

1.10 Identification Cards

The term "Identification Cards" ("ID Cards") shall mean printed identification cards containing specific information about the prescription drug benefits to which the Plan Participants are entitled. All ID Cards shall have the applicable ProAct pharmacy

network logo or other method of identifying the fact that ProAct is the provider of the prescription drug benefit in a form acceptable to ProAct.

1.11 Implementation Date

The term "Implementation Date" shall mean the date upon which ProAct completes the input of Plan Sponsor's Plan Participants List, unless such date is extended because Plan Sponsor's data required conversion or is in a format that is unacceptable to ProAct, pursuant to Section 3.2.

1.12 Maximum Allowable Cost or MAC

The term "Maximum Allowable Cost" or "MAC" shall mean the unit price that has been established by ProAct for a multi-source drug (i.e., a drug with more than two sources) included on the MAC drug list applicable to Plan Sponsor, which list may be amended from time to time by ProAct in maintaining its generic pricing program. Plan Sponsor acknowledges that the MAC list applicable to Plan Sponsor is not the same as the MAC published by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration, or "HCFA MAC").

1.13 Participating Pharmacies

The term "Participating Pharmacies" shall mean those organizations which contract with ProAct to provide Pharmacy Drug Services for Plan Participants and shall include, but shall not be limited to, walk-ins, mail order, specialty injectible and e-commerce vendors.

1.14 Pharmaceutical Manufacturer

The term "Pharmaceutical Manufacturer" shall mean a pharmaceutical company which has entered into an agreement with ProAct to offer discounts for pharmaceutical products.

1.15 Pharmacy Network

The "Pharmacy Network" consists of a retail pharmacy network, established and maintained by ProAct, to provide covered prescription drugs and other products.

1.16 Pharmacy Network Management

The term "Pharmacy Network Management" shall mean ProAct's responsibility for contract reimbursement negotiations as well as provider relations with Participating Pharmacies. Reimbursement negotiations shall include: i) payment terms; ii) method of payment; iii) timeliness of payment; and iv) access fees, as well as any other issues related to payment to Participating Pharmacies. Provider relations shall include: i) store information updates; ii) credentialing; iii) contract compliance; and iv) Plan Participant service issues, as well as any other issues related to the relationship with Participating Pharmacies.

1.17 Plan Participants

The term "Plan Participants" shall mean those individuals who are entitled to Prescription Drug Services under the Plan as identified by Plan Sponsor as set forth in Plan Sponsor's eligibility file prepared and maintained by Plan Sponsor and delivered to ProAct.

1.18 Plan Participants List
The term "Plan Participants List" shall have the meaning set forth in Section 3.2.

1.19 Prescription Drug Services
The term "Prescription Drug Services" shall mean all claims processing, reporting, rebate administration, pharmacy network management and other pharmacy benefit management services to be provided by ProAct pursuant to this Agreement.

1.20 Protected Health Information or PHI
The terms "Protected Health Information" or "PHI" shall have the meaning given such terms by HIPAA but limited to that information created or received by ProAct in its capacity as a business associate to the Benefit Plan.

1.21 Rebates
The term "Rebates" shall mean the formulary rebates, including base and market share rebates, collected by ProAct in its capacity as a group purchasing organization for the Benefit Plan from various pharmaceutical companies that are attributable to the utilization of single source brand prescription drugs by Plan Participants.

ARTICLE 2
PROACT SERVICES

2.1 Claims Processing Services. ProAct shall provide Claims processing services related to Claims for prescriptions dispensed on or after the Effective Date of this Agreement. ProAct shall process Claims received from Participating Pharmacies and Plan Participants, determine whether such Claims qualify for reimbursement in accordance with the terms of the applicable Benefit Plan and determine the applicable payment. ProAct agrees to process Claims within National Council for Prescription Drug Programs (NCPDP) prevailing standards. ProAct shall process Claims within the time frames established by applicable state and federal law. Upon termination of this Agreement, ProAct shall be obligated to process only those Claims which are for prescriptions dispensed before the termination date and which are received by ProAct within ninety (90) days of the termination date. Any Claims submitted and processed after the termination date will be invoiced at the rates set forth for such Claims in Exhibit A.

ProAct shall arrange for the following services to be provided upon receipt of a Claim:

(a) Verify that the patient for which the prescription has been claimed is a Plan Participant and is entitled to Prescription Drug Services.

(b) If applicable, verify that the prescriber is an authorized prescriber under the Benefit Plan.

(c) Verify that the medication dispensed is a drug covered by the Benefit Plan.

2.2 Collection of Copayment by Participating Pharmacies. Prior to providing to a Plan Participant any Prescription Drug Services to which such Plan Participant is or may be entitled under a Benefit Plan, Participating Pharmacies shall be required to collect from Plan Participant the amount of any applicable Copayment. Participating Pharmacies shall not recover from Plan Participants any unpaid balances due Participating Pharmacies from ProAct or Plan Sponsor.

2.3 Mail Order Delivery Pharmacy. ProAct shall provide mail order home delivery services through PROACT Pharmacy Services as follows:

(a) Dispense new or refill prescriptions following receipt from a Plan Participant of a prescription and a completed order or refill order form and any applicable Copayment;

(b) Fill prescriptions subject to the professional judgment of the dispensing pharmacist, good pharmacy practices in accordance with local community standards and product labeling guidelines; and

(c) Ship all filled prescriptions to Plan Participants via United States postal service or other appropriate carriers to the address provided by the Plan Participant.

2.4 Direct Plan Participant Reimbursement. To the extent authorized by the Benefit Plan, ProAct or Plan Sponsor shall provide Plan Participants with a ProAct (and Plan Sponsor approved) Claim form for use for reimbursement for Prescription Drug Services provided by a Participating or non-Participating Pharmacy. When such a Claim is submitted on the approved form, ProAct shall process the Claim according to the Benefit Plan and in the amount approved by Plan Sponsor for payment.

2.5 Claim Submission. Plan Sponsor acknowledges that ProAct shall require the Participating Pharmacies to send to ProAct, at the expense of the Participating Pharmacies, Claims via on-line point-of-sale terminals ("POS"), and/or on the Universal Claim Forms ("UCF"), and/or magnetic tapes or diskettes containing Claims information. Incorrect Claims will be denied. The Claim forms shall be sent to:

ProAct, Inc.
1230 US Highway 11
Gouverneur, New York 13642
Attention: Helpdesk

or at such other address designated by ProAct upon written notice.

2.6 Pharmacy Network Administration. ProAct shall contract with Participating Pharmacies at various reimbursement rates throughout the term of the Agreement, and shall charge Plan Sponsor a blended reimbursement rate which may be greater or less than the actual

rate paid to Participating Pharmacies. Plan Sponsor acknowledges and agrees that such difference in provider discount, if any, shall be retained by ProAct as compensation for administering the pharmacy network.

2.7 Therapeutic Alternative Program. Generic substitutions may be conducted through ProAct's mail order delivery service pharmacies and Participating Pharmacies under a program that substitutes brand name drugs with generic equivalents or therapeutic alternatives, where available and clinically appropriate, unless (i) the prescriber requires the prescription to be dispensed as written and does not authorize generic substitution; or (ii) the Plan Participant has notified the dispensing pharmacy to dispense the brand name drug only.

2.8 Payments to Participating Pharmacies. ProAct shall pay to the Participating Pharmacies, on behalf of Plan Sponsor, such reimbursement as may be agreed upon by Plan Sponsor and ProAct for dispensing of prescriptions to Plan Participants no later than fourteen (14) business days from confirmation of receipt of funds from Plan Sponsor for this purpose.

2.9 Transaction Charges. Participating Pharmacies shall be responsible for any applicable transaction charges associated with the submission of Claims to ProAct. Such charges are to be deducted by ProAct from the reimbursements to such Participating Pharmacies. Reimbursement checks to Participating Pharmacies using POS, Pharmacy Computer Systems and UCF for Claims processing will be paid in the net amount of the Claim after deduction by ProAct of all applicable transaction charges.

2.10 Customer Service for Pharmacy and Plan Participant Inquiries. ProAct shall be responsible for responding to inquiries from Participating Pharmacies and Plan Participants regarding the services provided by ProAct under this Agreement through a ProAct toll-free phone line. Services to be provided by ProAct include providing answers to questions on eligibility, Benefit Plan guidelines, deductibles, Copay levels, maximum benefit status, instructions on completing a direct Plan Participant reimbursement claim form and status of direct Plan Participant reimbursement claims.

2.11 Hours of Service. ProAct's 800 Help Line shall be available to Plan Sponsors, Participating Pharmacies and Plan Participants during ProAct's regular hours of business. These hours shall be Monday through Friday, 7:00 am to 8:00 pm, Eastern Standard Time (EST) and Eastern Daylight Time (EDT) and Saturday, 8:00 am to 5:00 pm, EST and EDT. These hours do not include national holidays and may be changed at any time. ProAct shall notify Plan Sponsor and the Participating Pharmacies prior to any changes to the schedule of business hours.

2.12 Pharmacy Audits. ProAct shall maintain criteria, which it may amend from time to time, to establish when and how a Participating Pharmacy shall be audited to determine compliance with its contract with ProAct. The audit may be conducted by ProAct's internal auditors or its outside auditors or by ProAct's review of electronically transmitted Claims. On-site pharmacy audits shall be conducted on a contingency basis. ProAct shall

not be required to institute any action to collect any overpayments to Participating Pharmacies.

2.13 Core Reports. ProAct shall prepare and deliver to Plan Sponsor core claims reports no later than thirty (30) days from the close of each quarter. Additional or customized reports shall incur costs to Plan Sponsor as described in Exhibit A.

2.14 Eligibility and Benefit Plan Changes. ProAct shall load Plan Participant data into the ProAct system no later than five (5) business days from receipt of such data. ProAct shall have thirty (30) days to implement any changes in any coverage criteria used by Plan Sponsor that require customized edits. The charges, as determined by agreement between ProAct and Plan Sponsor, for the necessary custom programming to implement any such customized edit will be borne by Plan Sponsor unless otherwise agreed by the parties. Plan Sponsor shall be bound by the change date requirements as described in Section 4.2 of this Agreement.

2.15 Plan Participant Services. Plan Participants shall be able to view their personal drug history for retail and mail order medications, expenditures and Copayments.

2.16 Government Agency Submitted Claims. Plan Sponsor acknowledges that government agencies may seek eligibility or similar data from ProAct regarding Plan Participants. Additionally, government agencies, or their agents, may submit to ProAct claims for reimbursement for prescription drug benefits provided by such government agencies to Plan Participants ("Government Claims"). Plan Sponsor authorizes ProAct to provide such data as requested by government agencies or their agents and further authorizes ProAct to process such Government Claims on behalf of Plan Sponsor. Plan Sponsor shall reimburse ProAct for all amounts advanced by ProAct for payment of Government Claims. Plan Sponsor acknowledges that Government Claims submitted by or on behalf of a state Medicaid agency shall be paid if submitted within three (3) years from the original date of fill unless a longer period is required by applicable law. In addition, Government Claims submitted by or on behalf of a state Medicaid agency may not be denied on the basis of the format of the Government Claim or failure to present proper documentation at the point-of-sale. Plan Sponsor shall also reimburse ProAct for any adjustments or reconciliations to previously processed Government Claims that may be payable to government agencies in accordance with applicable laws and regulations. ProAct reserves the right to (i) terminate these services upon ninety (90) days' prior written notice to Plan Sponsor; or (ii) delegate these services to a third party claims processor.

2.17 Non-Standard or Excessive Services or Materials. In the event Plan Sponsor requests non-standard Identification Cards, services, forms, materials or documents, or standard services, forms, materials or documents in an amount which ProAct determines to be unreasonable or excessive, Plan Sponsor shall be charged for such additional services as provided based on the fee structure described in Exhibit A.

2.18 Additional Services. In the event that Plan Sponsor requests ProAct to provide services other that those described herein, including special research projects, special reports, consultative services (e.g., HIPAA compliance consultation), ProAct system changes to accommodate changes in Plan Sponsor's Benefit Plan or system, or other tasks to be specifically performed for or on behalf of Plan Sponsor, Plan Sponsor shall pay to ProAct an additional charge to be mutually agreed upon by the parties in writing before the services are provided.

ARTICLE 3
IMPLEMENTATION

3.1 Implementation Services. ProAct shall provide standard implementation services to Plan Sponsor at no additional charge. In consultation with Plan Sponsor, ProAct shall develop a mutually agreeable implementation plan prior to the Effective Date. .

3.2 Plan Participant Lists. Plan Sponsor shall provide to ProAct (i) a full file list of Plan Participants (including eligible dependents) as described in Section 4.1 hereof at least fourteen (14) days prior to the Implementation Date in a format acceptable to ProAct; (ii) the governing Benefit Plan, including a summary plan description; and (iii) such other information required by Section 4.2 hereof describing the Plan Sponsor's Benefit Plan to be used by ProAct to provide Prescription Drug Services under the terms of this Agreement.

ARTICLE 4
DUTIES TO BE PERFORMED BY PLAN SPONSOR

4.1 Eligibility Data. Plan Sponsor shall provide to ProAct all information concerning the Prescription Benefit Plan and Plan Participants necessary for ProAct to perform the Prescription Drug Services, including all updates thereto, on a daily basis and at least fourteen (14) days prior to the Implementation Date. Plan Sponsor shall be responsible for ensuring the accuracy of the Eligible Member List and Plan Sponsor shall be obligated to pay ProAct for Claims accepted by ProAct that are submitted by or on behalf of persons listed on any Plan Participants List. Plan Sponsor shall bear the entire risk of all fraudulent Claims submitted by Plan Participants or by unauthorized persons using a Plan Participant's ID Card or identification number. The Plan Participant List shall contain the following minimum information:

- Plan Participant's identification number;
- Plan Participant's full name (last, first, and middle initial);
- Plan Participant's date of birth;
- Plan Participant's address;
- the names of dependents;
- the dates of birth for dependents;
- the date the Plan Participant's participation in Prescription Drug Services under the Benefit Plan becomes effective;

- the date the Plan Participant's participation in Prescription Drug Services under the Benefit Plan is terminated;
- the Benefit Plan group number

Plan Sponsor agrees to indemnify ProAct for any damages related to Plan Sponsor's failure to provide accurate and timely data described in this Section 4.1.

4.2 Benefit Plan Information. Thirty (30) days prior to the Effective Date hereof, Plan Sponsor will deliver to ProAct detailed Benefit Plan Information. Such information shall contain all of the elements required by ProAct so that ProAct may verify and price the Claims submitted by Participating Pharmacies, and to prepare the various reports as described in this Agreement. In addition, Plan Sponsor shall provide any Benefit Plan Information changes to ProAct immediately, preferably thirty (30) days prior the date such changes shall become effective (the "Change Date"), except that changes to Benefit Plan Information that are to be effective on January 1 of any given year must be provided to ProAct at least ninety (90) days prior to January 1. Failure to provide Benefit Plan Information changes within the time frames described in this Section 4.2 may result in postponement of the proposed Change Date. Plan Sponsor shall also provide to ProAct copies of and any subsequent changes to the applicable plan document, certificate of insurance or summary plan description documentation containing Benefit Plan Information related to the Prescription Drug Services administered by ProAct under this Agreement.

4.3 Notification Requirements. Plan Sponsor will review all reports, statements, and invoices provided by ProAct and shall notify ProAct in writing of any errors or objections within thirty (30) days of receipt. Specifically, this shall also apply to all service requests, benefit change request forms, pharmacy operations change requests or any notification resulting from an independent audit. Until Plan Sponsor notifies ProAct in writing of any errors or objections, ProAct will be entitled to rely on the information contained in the reports, statements, and invoices. If Plan Sponsor does not notify ProAct in writing of any errors or objections within the thirty (30) day period, the information contained therein will be deemed accurate, complete, and acceptable to Plan Sponsor, and thereafter ProAct shall have no liability related thereto. This does not apply with respect to any undercharges or underpayments of Plan Sponsor.

4.4 Plan Participant Copayments. ProAct may, but shall not be obligated to, dispense a prescription even if the prescription is not accompanied by the applicable Copayment. ProAct will credit any amount submitted by Plan Participant in excess of the Plan Participant's Copayment. In the event a Plan Participant submits to ProAct an insufficient Copayment and the Plan Participant fails to remit the balance of the Copayment amount to ProAct within thirty (30) days of ProAct's request, then ProAct shall have the right to invoice Plan Sponsor and Plan Sponsor shall have an obligation to pay ProAct the amount of the uncollected Copayment.

ARTICLE 5
PAYMENTS DUE PROACT

5.1 Invoicing. ProAct shall invoice Plan Sponsor for claims on a bi-weekly basis. Plan Sponsor shall remit to ProAct via overnight mail the full amount reflected on such invoices within ten (10) business days to the bank account designated by ProAct. Should said amount not be remitted via overnight mail within ten (10) business days, Plan Sponsor shall be subject to interest charged on all overdue amounts at an amount equal to one and one-half percent (1.5%) per month, to accrue on a daily basis. If Plan Sponsor questions the amount of the Statement, Plan Sponsor may notify ProAct of its questions regarding said amount but shall remain obligated to send via overnight mail the full amount of the invoice. If ProAct receives such a notice, it shall make a commercially reasonable effort to respond to such questions within five (5) business days.

5.2 Suspension of Services. In the event amounts due ProAct under Section 5.1 are more than two (2) days' past due and payment has not yet been sent via overnight mail to a ProAct designated bank account, then ProAct may give notice to Plan Sponsor of ProAct's intent to suspend its services and system operations. At any time thereafter, ProAct may terminate this Agreement as provided in Article 12 of this Agreement. Plan Sponsor shall be responsible for all costs of collection and agrees to reimburse ProAct for such costs and expenses, including reasonable attorneys' fees.

5.3 Deposit. In the event Plan Sponsor fails to remit its full payment within ten (10) business days of its receipt of ProAct's invoice three (3) or more times during any twelve (12) month period, ProAct shall have the option, in its sole discretion, to collect from Plan Sponsor a deposit in an amount equal to the average invoice amount over the previous six (6) months, or, if there is a less than six (6) months' billing history, then such deposit shall be equal to the average invoice amount over the actual billing history. ProAct shall retain the deposit until the termination of this Agreement, at which time such deposit shall be returned, without interest, less any offsets for payment defaults and collection costs (in accordance with Section 5.5 below).

5.4 Sale and Use Taxes. The parties hereby agree that the payment of any and all state and local sales taxes and use taxes attributable to any Prescription Drug Services delivered pursuant to this Agreement shall be the sole and exclusive obligation of Plan Sponsor.

5.5 Offsets. In the event of any uncured payment default, Plan Sponsor hereby authorizes ProAct to offset the amount of such payment defaults and collection costs against any amounts otherwise payable to Plan Sponsor (including any Rebate amounts as provided in Article 7) or Plan Sponsor's deposit (as described in Section 5.3 above).

ARTICLE 6
RECORDS

6.1 Maintenance of Records. ProAct shall maintain, in the original form or other media, the Claims received from the Pharmacy Network and adequate records to establish payment to the Pharmacy Network. Upon prior written notification to ProAct, Plan Sponsor shall have access to such records during normal business hours.

6.2 Use of Information. ProAct and Plan Sponsor may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of HIPAA, and may not use the information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information and shall indemnify and hold the other party harmless for, from and against any and all costs, losses and damages incurred by such other party as a result of such use.

6.3 Ownership of Information. Without limiting the generality of Section 6.2, and subject to the restrictions set forth therein:

a. Claims data information provided to ProAct directly by Plan Sponsor shall be the property of Plan Sponsor.

b. Plan Sponsor agrees that the aggregate compilations of information contained in any and all databases developed by ProAct or its designees, and any prior and future versions thereof, are the property of ProAct and protected by copyright which shall be owned by ProAct.

c. ProAct, its agents, employees, and contractors shall have the right to use, reproduce, and adapt all information obtained in connection with this Agreement, to render services to ProAct's clients and to develop new products and services which may be outside the scope of this Agreement. Any work, compilation, processes, or inventions developed by ProAct or its agents, employees, or contractors pursuant to this Section 6.3 shall be owned by ProAct and deemed its confidential information.

6.4 Right to Audit Claims and Business Records. Plan Sponsor may inspect and audit once annually ProAct's business records that directly relate to billings made to Plan Sponsor for Claims. ProAct may inspect and audit, or cause to be inspected and audited, once annually the books and records of Plan Sponsor directly relating to this Agreement, including the existence and number of Plan Participants. Plan Sponsor and ProAct shall fully cooperate with representatives of each other and with representatives of any regulatory or accreditation agency in the conduct of any such inspection or audit. Such audits shall be at the auditing party's sole expense and shall only be made during normal

business hours, following fifteen (15) days' written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. An audit of ProAct's records shall be conducted at ProAct's office where such records are located and shall be limited to transactions over the twelve (12) month period preceding such audit. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

ARTICLE 7
REBATE ADMINISTRATION

7.1 Appointment of ProAct as Agent. Plan Sponsor appoints ProAct as its exclusive agent for the purpose of negotiating and arranging for Rebates on the purchase of prescription drugs from Pharmaceutical Manufacturers. ProAct agrees that it will comply with all applicable state and federal laws and regulations regarding the administration of Rebates on the purchase of prescription drugs. Plan Sponsor represents that it does not have any existing direct rebate and/or chargeback agreements with any Pharmaceutical Manufacturer and also agrees that during the term of this Agreement Plan Sponsor will not negotiate or arrange for rebates on the purchase of Prescription Drug Services from any Pharmaceutical Manufacturer. In the event Plan Sponsor negotiates directly with a Pharmaceutical Manufacturer for rebates on the purchase of prescription drugs, ProAct may immediately terminate Plan Sponsor's participation in ProAct's Rebate program.

7.2 Participation in Program. Plan Sponsor shall be eligible to receive rebates from certain Pharmaceutical Manufacturers for prescription drugs dispensed to Plan Participants who are covered by Benefit Plans which meet the following criteria:

- Develop, publish and distribute a drug formulary or other drug product selection guide consistent with ProAct's recommended drug Formulary and preferred product list, including all subsequent revisions;

- Provide feedback to Plan Sponsor to ensure compliance with Plan Sponsor's drug formulary via established communication mechanisms (e.g., retrospective drug utilization review/evaluation programs, provider newsletters, contract compliance programs); and

- Meet the eligibility criteria of each of the respective Pharmaceutical Manufacturers for plan applicable agreements.

7.3 Rebate Disclosure. Plan Sponsor agrees that it will fully comply with ERISA. In providing services under this Agreement, ProAct is not acting as a fiduciary (as defined in Section 3.21(a) of ERISA) of Plan Sponsor's prescription drug program and Plan Sponsor shall not name ProAct as a "plan fiduciary."

7.4 Eligible Rebate Data. Claims which have been submitted to: (i) Medicaid; (ii) Medicare; or (iii) any other state or federal health care program which receives rebates, discounts, chargebacks or other forms of price reduction directly from Pharmaceutical Manufacturers shall not be eligible to participate in ProAct's Rebate program. Plan Sponsor will not contract, directly or indirectly, with any other entity for discounts, rebates or financial incentives on pharmaceutical products or formulary programs for claims processed by ProAct pursuant to this Agreement. In the event Plan Sponsor negotiates or arranges with a pharmaceutical manufacturer for rebates or similar discounts and any Pharmaceutical Manufacturer's audit of ProAct's Rebate program reveals improperly calculated rebates, then Plan Sponsor shall be solely responsible for the reimbursement of any Rebates improperly made and the cost of the audit services.

7.5 Other Pharmaceutical Relationships. Nothing in this Article 7 shall preclude ProAct from pursuing other, independent sources of revenue from Pharmaceutical Manufacturers and engaging in other revenue-producing relationships with Pharmaceutical Manufacturers.

ARTICLE 8
INDEMNIFICATION

8.1 Indemnity by Plan Sponsor. Plan Sponsor shall indemnify and hold ProAct, its officers, directors, shareholders, employees, successors, other agents and assigns ("ProAct Indemnitees"), harmless from and against any claims, liabilities, damages, judgments or other losses (including attorneys' fees) imposed upon or incurred by ProAct Indemnitees arising out of or as a result of any acts or omissions of Plan Sponsor, its officers, directors, employees or other agents, in connection with the performance of any of their respective obligations under this Agreement, including, without limitation, the submission to Participating Pharmacies or Pharmaceutical Manufacturers of inaccurate or false information provided by Plan Sponsor.

8.2 Indemnity by ProAct. ProAct shall indemnify and hold Plan Sponsor and its officers, directors, shareholders, employees, successors, other agents and assigns ("Plan Sponsor Indemnitees"), harmless from and against any claims, liabilities, damages, judgments or other losses (including attorneys' fees) imposed upon or incurred by Plan Sponsor Indemnitees arising out of or as a result of any acts or omissions of ProAct, its officers, directors, employees or other agents, in connection with the performance of any of their respective obligations under this Agreement.

8.3 Limitation of Liability. ProAct relies on Medi-Span or First Data Bank or other industry comparable databases in providing Plan Sponsor and Plan Participants with Claims adjudication and drug utilization review services. ProAct has utilized due diligence in

collecting and reporting the information contained in the databases and has obtained such information from sources believed to be reliable. ProAct, however, does not warrant the accuracy of reports, alerts, codes, prices or other data contained in the databases. The clinical information contained in the databases and the Formulary is not intended as a supplement to, or a substitute for, the knowledge, expertise, skill, and judgment of physicians, pharmacists, or other healthcare professionals involved in Plan Participants' care. The absence of a warning for a given drug or drug combination shall not be construed to indicate that the drug or drug combination is safe, appropriate or effective for any Plan Participant.

IN NO EVENT SHALL PROACT OR ANY AFFILIATE OF PROACT BE LIABLE TO PLAN SPONSOR OR ANY PLAN PARTICIPANT OR ANY AFFILIATE FOR ANY INDIRECT, SPECIAL OR CONSEQUENTIAL DAMAGES OR LOST PROFITS ARISING OUT OF OR RELATED TO PROACT'S PERFORMANCE UNDER THIS AGREEMENT OR BREACH THEREOF, EVEN IF PROACT HAS BEEN ADVISED OF THE POSSIBILITY THEREOF. PROACT'S LIABILITY TO PLAN SPONSOR, PLAN PARTICIPANTS OR ANY AFFILIATE UNDER THIS AGREEMENT, IF ANY, SHALL IN NO EVENT EXCEED THE TOTAL AMOUNT OF COMPENSATION PAID TO PROACT BY PLAN SPONSOR FOR ADMINISTRATIVE SERVICES FOR THE PRIOR TWELVE (12) MONTHS FROM THE DATE THE CLAIM IS ASSERTED.

ARTICLE 9
DISPUTE RESOLUTION PROCEDURE

9.1 Resolution of Disputes. The parties agree that any and all disputes arising out of, or relating to, this Agreement shall first be addressed by direct negotiation between the parties. The disputing party shall provide the other party with written notice of the dispute ("Notice of Dispute"), containing a detailed description of the matter in controversy. The parties agree to exercise reasonable commercial efforts to resolve the dispute as soon as practicable.

ARTICLE 10
CONFIDENTIALITY

10.1 Confidential Information. The term "Confidential Information" means information of a confidential or proprietary nature relating to the subject matter described in this Agreement which is taken from or disclosed by one party (the "Disclosing Party") to the other (the "Receiving Party"). Confidential Information includes, but is not limited to, matters of a technical nature such as trade secrets, methods, compositions, data and know-how, designs, systems, processes, computer programs, files and documentation, similar items or research projects and any information derived therefrom; matters of a business nature, such as the terms of this Agreement (including any pricing terms and Pharmaceutical Manufacturer contract terms), marketing, sales, strategies, proposals, and lists of actual or potential Plan Participants, Participating Pharmacies and Pharmaceutical

Manufacturers; as well as any other information that is designated by either party as confidential.

10.2 Treatment of Confidential Information. The Receiving Party agrees: (i) to hold the Disclosing Party's Confidential Information in strict confidence and to take reasonable precautions to protect such Confidential Information (including, without limitation, all precautions Receiving Party employs with respect to its own confidential materials); (ii) not to divulge any such Confidential Information or any information derived therefrom to any third party unless required in the performance of the Receiving Party's duties under this Agreement; (iii) not to make any use whatsoever at any time of such Confidential Information except for the purpose of this Agreement nor use it for its own or any third party's benefit; and (iv) not to copy, analyze, transcribe, transmit, decompile, disassemble or reverse engineer any such Confidential Information nor use such Confidential Information in any patent application. The confidentiality obligations of this Section 10.2 shall not apply to information which, as evidenced in writing, (a) is or becomes publicly known by Receiving Party through no breach of this Agreement; (b) is learned by the Receiving Party from a third party entitled to disclose it; or (c) is rightfully obtained by the Receiving Party prior to this Agreement.

Receiving Party may make disclosures required by law or court order provided Receiving Party uses diligent, reasonable efforts to limit disclosure and to obtain confidential treatment or a protective order and has allowed the Disclosing Party to participate in the proceeding.

10.3 Injunctive Relief. Receiving Party acknowledges that it shall not acquire any rights or title to any Confidential Information merely by virtue of its use or access to such Confidential Information hereunder. Neither the execution of this Agreement nor the furnishing of any Confidential Information hereunder shall be construed as granting, either expressly or by implication or otherwise, the Receiving Party any license under any invention or patent now or hereafter owned by or controlled by the Disclosing Party. Each party agrees that it may not be adequately compensated for damages arising from a breach or threatened breach of any of the covenants contained in this Article 10 by the other party, and each party shall be entitled to injunctive relief and specific performance in addition to all other remedies. None of the information that may be submitted or exchanged by the parties shall constitute any representation, warranty, assurance, guarantee, or inducement by a party to the other with respect to the infringement of patents, copyrights, trademarks, trade secrets, or any other rights of third persons.

ARTICLE 11
EXCLUSIVITY

11.1 Exclusivity. Plan Sponsor agrees that ProAct shall be the sole and exclusive agent for Plan Sponsor for each of the services described herein during the term of this Agreement Notwithstanding the foregoing, this Section shall not be construed to prohibit Plan Sponsor from including pharmacy coverage under a fully insured medical/prescription

benefit plan. Plan Sponsor acknowledges and agrees that Plan Sponsor shall not engage any prescription benefit manager or other third party to provide to Plan Sponsor or its Benefit Plan any service that is similar to one of the Prescription Drug Services provided by ProAct, including, without limitation, retail pharmacy network contracting, pharmacy claims processing, mail pharmacy services and formulary and rebate administration services. Plan Sponsor acknowledges and agrees that a breach of this Section 11.1 shall be deemed a material breach of this Agreement and shall entitle ProAct to modify pricing terms pursuant to Section 13.2 of this Agreement.

ARTICLE 12
TERM AND TERMINATION

12.1 Term. This Agreement shall become effective on the Effective Date and shall be for a term of three (3) years and thereafter shall continue in effect for additional one (1) year terms unless terminated on its anniversary date by either party by certified mail, mailed at least ninety (90) days prior to such date. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

12.2 Termination For Cause. This Agreement may be terminated at any time by either party based on a material breach of any terms or conditions herein stated provided that sixty (60) days' advance written notice of such material breach shall be given to the other party and such party shall have the opportunity to cure such material breach during such sixty (60) day notice period.

12.3 Termination Due to Non-Payment. Notwithstanding the termination rights described in Section 12.2, above, in the event Plan Sponsor fails to timely remit to ProAct the full amount of payment (and any interest accrued thereon) as set forth in Section 5.1 above, and such payment (plus interest, if any) is not received by ProAct within the time limits set forth in Section 5.2 above, ProAct may terminate this Agreement on any date thereafter, effective on the date notice of such termination is received by Plan Sponsor.

12.4 Effect of Termination. If this Agreement is terminated pursuant to this Article 12: (i) all further obligations of the parties under this Agreement shall terminate (but not such party's obligation to make payments arising prior to the termination of this Agreement or any obligation surviving the termination hereof); (ii) all Confidential Information provided by either party shall, except for Confidential Information required by law to be retained by a party, be immediately returned by a Receiving Party (as defined in Section 10.1), or such Receiving Party shall certify to the Disclosing Party that such materials have been destroyed; (iii) should ProAct have a deposit from Plan Sponsor (as described in Section 5.3, above), such deposit shall be reduced by any offsets for payment defaults and collection costs (as described in Section 5.5 above) before being returned; (iv) neither party shall be relieved of any obligation or liability arising from any prior breach of such party of any provision of this Agreement; and (v) the parties shall, in all events, remain

bound by and continue to be subject to the provisions set forth in Sections 6.1, 6.3, 6.4, 7.3, 8.1, 8.2, 8.3, 9.1, 10.1, 10.2, 10.3, 13.1, 13.2, 13.8, 13.9, 13.11, 13.12 and 13.20.

ARTICLE 13
GENERAL PROVISIONS

13.1 Use of ProAct Software. Plan Sponsor acknowledges that ProAct owns or possesses license rights (including off-the-shelf vendor agreements) from certain third parties to the entire software system used by ProAct in processing Claims and preparing reports, including computer programs, system and program documentation, and other documentation relating thereto (collectively, including certain license rights, the "ProAct Software System") and that the ProAct Software System is the exclusive and sole property of ProAct.

13.2 Pricing Assumptions. Upon thirty (30) days' prior written notice to Plan Sponsor, ProAct may modify or amend the financial provisions of this Agreement in a manner which accounts for the impact of the events identified below. Such notice will include ProAct's explanation of the manner in which the modification accounts for the impact of the event:

(a) Any government-imposed or industry-wide change that would impede ProAct's ability to provide the pricing described in this Agreement, including any prohibition or restriction on the ability to receive rebates or discounts for pharmaceutical products;

(b) Implementation or addition of a high deductible health plan/consumer-driven health plan option;

(c) Implementation or addition of a member-paid plan;

(d) A greater than twenty percent (20%) change in the total number of Plan Participants from the number provided during pricing negotiations; or

(e) A change in the coverage of Medicare-eligible Plan Participants, irrespective of the resulting change in total number of Plan Participants, as defined above.

13.3 Insurance. Each party shall obtain and maintain, with respect to the activities in which such party engages pursuant to this Agreement, professional liability (errors and omissions) insurance in amounts reasonable and customary for the nature and scope of business engaged in by such party and comprehensive liability insurance. Upon request, either party shall promptly deliver to the other party evidence of such insurance. Each party agrees to notify the other party immediately upon such party's receipt of any notice canceling, suspending or reducing the coverage limits of its professional liability insurance or comprehensive liability insurance.

13.4 Successors and Assigns. Neither this Agreement nor any of the rights, interests or obligations hereunder shall be assigned by either party hereto without the prior written consent of the other party hereto. Subject to the preceding sentence, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the parties and their respective successors and permitted assigns. Notwithstanding anything to the contrary contained in this Agreement (including this Section 13.4), no consent shall be required and this Agreement will apply to, be binding in all respects upon, and inure to the benefit of any successors of Plan Sponsor to this Agreement resulting from a Change of Control. A "Change of Control" shall occur if, as a result of one or a series of related transactions: (i) all or substantially all the assets of Plan Sponsor are disposed of to any entity not wholly owned and controlled by Plan Sponsor, outside the ordinary course of business; (ii) Plan Sponsor effects a merger with one or more other entities in which Plan Sponsor is not the surviving entity; or (iii) Plan Sponsor engages in a transaction that results in any entity holding securities possessing a majority of the voting power that does not hold such voting power as of the time of this Agreement.

13.5 Waiver. Any term or condition of this Agreement may be waived at any time by the party that is entitled to the benefit thereof, but no such waiver shall be effective unless set forth in a written instrument duly executed by or on behalf of the party waiving such term or condition. No waiver by any party of any term or condition of this Agreement, in any one or more instances, shall be deemed to be or construed as a waiver of the same or other term or condition of this Agreement on any future occasion.

13.6 Severability. In the event that any provision of this Agreement shall be determined to be invalid, unlawful, void or unenforceable to any extent, the remainder of this Agreement, and the application of such provision other than those as to which it is determined to be invalid, unlawful, void or unenforceable, shall not be impaired or otherwise affected and shall continue to be valid and enforceable to the fullest extent permitted by law.

13.7 Further Assurances. Each party hereto shall execute and cause to be delivered to each other party hereto such instruments and other documents, and shall take such other actions, as such other party may reasonably request (at or after the date hereof) for the purpose of carrying out or evidencing any of the transactions contemplated by this Agreement.

13.8 Choice of Law. This Agreement shall be construed, interpreted and governed according to the laws of the State of New York.

13.9 Non-Competition in Hiring. During the term of this Agreement, and for a period of one (1) year thereafter, neither party shall, without the prior written consent of the other party, knowingly employ or solicit for hire, or knowingly allow its officers, directors, agents or affiliates to employ or solicit for hire, any employees of the other party.

13.10 Force Majeure. The performance obligations of ProAct and/or Plan Sponsor respectively hereunder shall be suspended to the extent that all or part of this Agreement cannot be

performed due to causes which are outside the control of ProAct and/or Plan Sponsor and could not be avoided by the exercise of due care, including, but not limited to, acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive or terrorist activity or sabotage, fires, floods, earthquakes, explosions, strikes, slow-downs, freight embargoes, or by any enforceable law, regulation or order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement. In order to benefit from the provisions of this Section 13.10, the party claiming force majeure must notify the other reasonably promptly in writing of the force majeure condition. If any event of force majeure, in the reasonable judgment of the parties, is of a severity or duration such that it materially reduces the value of this Agreement, then this Agreement may be terminated without liability or further obligation of either party (except for any obligation expressly intended to survive the termination of this Agreement and except for all amounts that have become or will become due and payable hereunder).

13.11 Entire Agreement; No Third Party Beneficiaries. This Agreement, including the Exhibits: (i) constitutes the entire agreement among the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings, both written and oral, among the parties with respect to the subject matter hereof; and (ii) is intended solely for the benefit of each party hereto and their respective successors or permitted assigns, and it is not the intention of the parties to confer third party beneficiary rights, and this Agreement does not confer any such rights, upon any other third party.

13.12 Use of Name. Neither party shall use the other party's name, trade or service mark, logo, or the name of any affiliated company in any advertising or promotional material, presently existing or hereafter established, except in the manner and to the extent permitted by prior written consent of the other party.

13.13 Notice. Any notice required or permitted by this Agreement, unless otherwise specifically provided for in this Agreement, shall be in writing and shall be deemed given: (i) one (1) day following delivery to a nationally reputable overnight courier; (ii) one (1) day following receipt by facsimile during the receiving party's business hours with written confirmation thereof; or (iii) three (3) days after the date it is deposited in the United States mail, postage prepaid, registered or certified mail, or hand delivered addressed as follows:

To ProAct: ProAct, Inc.
6333 Route 298
East Syracuse, New York 13057

To Plan Sponsor: City of Rome
198 North Washington Street
Rome, New York 13440

Either party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

13.14 Counterparts; Facsimile. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more counterparts have been signed by each of the parties and delivered to the other parties, it being understood that all parties need not sign the same counterpart. This Agreement may be executed and delivered by facsimile and upon such delivery the facsimile signature will be deemed to have the same effect as if the original signature had been delivered to the other party. The original signature copy shall be delivered to the other party by express overnight delivery. The failure to deliver the original signature copy and/or the nonreceipt of the original signature copy shall have no effect upon the binding and enforceable nature of this Agreement.

13.15 Independent Contractors. Plan Sponsor and ProAct are independent entities and nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or franchiser and franchisee or any relationship, fiduciary or otherwise, other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Nothing in this Agreement is intended to be construed, or be deemed to create, any rights or remedies in any third party, including but not limited to a Plan Participant. Nothing in this Agreement shall be construed or deemed to confer upon ProAct any responsibility for or control over the terms or validity of the Prescription Drug Services. ProAct shall have no final discretionary authority over or responsibility for Plan Sponsor's administration. Further, because ProAct is not an insurer, plan sponsor, plan contract, third party administrator, or a provider of health services to Plan Participants, ProAct shall have no responsibility for: (i) any funding of Plan Sponsor's benefits; (ii) any insurance coverage relating to Plan Sponsor or any plan contract of Plan Sponsor or Plan Participants; or (iii) the nature or quality of professional health services rendered to Plan Participants.

13.16 Consent to Amend. This Agreement or any part or section of it may be amended at any time during the term of this Agreement only by mutual written consent of duly authorized representatives of ProAct and Plan Sponsor.

13.17 Headings. The headings of Articles, Sections and Exhibits contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

13.18 Compliance with Laws and Regulations. This Agreement will be in compliance with all pertinent federal and state statutes and regulations. If this Agreement, or any part hereof, is found not to be in compliance with any pertinent federal or state statute or regulation, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance. Each party shall comply with the provisions of all applicable laws relating to the performance of its obligations under this Agreement, including the federal

anti-kickback statute, set forth at 42 U.S.C. § 1320a-7b(b) (the "Anti-Kickback Statute"), and the federal "Stark Law," set forth at 42 U.S.C. § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Agreement.

13.19 Subcontracting. ProAct may subcontract any or all services to be provided under this Agreement.

13.20 HIPAA Compliance. For the purposes of this Agreement, ProAct is deemed to be a "Business Associate" or "Covered Entity" as such terms are defined by HIPAA. The parties will endeavor to comply with all applicable regulations published pursuant to HIPAA, as of the effective enforcement date of each standard. In addition, without limiting any other provision of this Agreement:

a. all services provided by ProAct under this Agreement will be provided in such a manner as to enable Plan Sponsor to remain at all times in compliance with all HIPAA regulations applicable to Plan Sponsor, to the extent that Plan Sponsor's compliance depends upon the manner in which such services are performed by ProAct;

b. all software, application programs and other products licensed or supplied by ProAct under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that Plan Sponsor's use of such software, application programs and other products and associate documentation from ProAct, when utilized by Plan Sponsor in the manner as directed by ProAct, will fully comply with the HIPAA regulations applicable to Plan Sponsor. In the event any amendment to this Agreement is necessary for Plan Sponsor to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, Plan Sponsor and ProAct will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations; and

c. all software, application programs, eligibility lists or other member-specific information and other products licensed or supplied by Plan Sponsor under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that ProAct's use of such software, application programs and other products and associate documentation from Plan Sponsor, when utilized by ProAct in the manner as directed by Plan Sponsor, will fully comply with the HIPAA regulations applicable to ProAct. In the event any amendment to this Agreement is necessary for ProAct to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to

Business Associate agreements, ProAct and Plan Sponsor will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations.

d. To the extent ProAct acts as a Business Associate of the Benefit Plan, ProAct shall adhere to applicable requirements established for Business Associates, as set forth in Exhibit B. In compliance with HIPAA, ProAct may share Plan Participant information as appropriate for the treatment, payment and health care operations of other health care providers or plans.

The provisions of this Agreement shall bind and inure to the benefit of the parties hereto and their heirs, legal representatives, successors and assignees. This Agreement constitutes the entire understanding between the parties hereto.

PROACT, INC.	**CITY of ROME**
_____	_____
BY	BY
David B. Warner	_____
NAME	NAME
President	_____
TITLE	TITLE
_____	_____
DATE	DATE

EXHIBIT A
ADMINISTRATIVE FEE SCHEDULE

CLAIMS PROCESSING FEE: PER PAID CLAIM	**$0.00**
REBATE SHARE TO PLAN SPONSOR	**85%**

PHARMACY RATES

Retail Network Pharmacy Rates:

Brand: The lesser of AWP -18% (14.7% Post AWP) + $1.35 dispensing fee, or U&C
Generic: The lesser of MAC or AWP -14.7% +$1.40 dispensing fee, or U&C (Generic Aggregate of AWP – 72%)

Mail Order Service Pharmacy:

Brand: AWP less 25% (22% Post AWP) + no dispensing fee
Generic: AWP less 74% + no dispensing fee

Specialty Drug Pricing:

AWP less 17% (13.7% Post AWP) + $1.50 dispensing fee, or U&C

1. Electronic magnetic media	No charge
2. Input and maintenance from hard copy	No charge
3. Clinical Prior Authorizations	$15.00 per Rx
4. Direct Member Reimbursements (paper claims)	$2.00 per paid claim
5. Member Identification Cards	No charge
6. Ad Hoc Reports	$150.00 per programming hour

7. Drug Utilization Review (DUR) Services	No charge
8. Out-of-pocket expenses	
Mailing expenses/postage	At meter cost
Air freight/overnight letters	At carrier cost
9. Shipping and handling charges	At cost
10. Standard Clinical Programs	
Step Therapy	$.08 PMPM
Concurrent DUR Edits	No Charge
Plan Design Changes	No Charge
Physician Profiling	No Charge
Administrative Overrides/Prior Authorizations	No Charge
Formulary Management	No Charge
Therapeutic Alternative Programs	No Charge
On-site Member Education Programs	No Charge
Over the Counter Drug Programs	No Charge
Half Tablet Program	No Charge
Direct Mail Utilization Program	No Charge
11. Optional Programs	
On-line Eligibility Access	$1,500 (3 year licensing fee)
Customized On-Site Wellness Programs	$75.00 per program hour
Retiree Drug Subsidy-Basic Services	No Charge
RDS Account Setup for Groups with fewer than 500 RDS Members	$5000 Admin setup fee
RDS Notice of Creditable Coverage	$1.25 per letter + postage
RDS Additional Subsidy Related Services (ProAct uploads cost reports to CMS)	$1.00 PMPM per Medicare-qualified members with minimum annual fee of $7,500
Actuarial Certification & Attestation	$350 per hour – as negotiated

12. Drug Rebates. ProAct shall remit to Plan Sponsor that portion of the Rebates as set forth above ("Plan Sponsor Rebates"), with the excess, if any, of actual Rebates over Plan Sponsor Rebates to be retained by ProAct as an additional service fee for the services provided under this Agreement. In lieu of billing Plan Sponsor for this fee, ProAct may retain the amount due from the Rebates collected by ProAct. No Rebate shall be credited for any generic Claim, whether such Claim is filled with a generic drug or by a brand-name drug dispensed in lieu of a generic drug reimbursement rate. Quarterly Rebate payment shall be made within sixty (60) days following the quarter collected. ProAct may adjust the Plan Sponsor Rebate payments in an

equitable manner if: (i) a generic version of a branded product is introduced in the market; or (ii) a branded product is recalled or withdrawn from the market.

EXHIBIT B
BUSINESS ASSOCIATE CONTRACT

This Business Associate Contract ("Contract") is entered into on January 1, 2014 ("Contract Effective Date") between the City of Rome, having a principal location at 198 North Washington Street, Rome New York 13440 ("Covered Entity"), and ProAct, Inc., having a principal location at 6333 Rte 298, East Syracuse, New York 13057 ("Business Associate") (Each a "Party" and collectively, the "Parties").

RECITALS:

A. Covered Entity will make available and/or transfer to Business Associate protected health information ("PHI") in order for Business Associate to carry out i) its contractual obligations under a contract between Covered Entity and Business Associate dated January 1, 2014 (the "Underlying Services Agreement" between the Parties) and/or ii) certain business responsibilities on behalf of Covered Entity.

B. Business Associate will have access to and/or receive from Covered Entity PHI that may be used or disclosed only in accordance with this Contract and the Privacy, Security, Breach Notification and Enforcement Regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, as set forth in the Code of Federal Regulations ("CFR") at Title 45, Parts 160 and 164, as may be amended (collectively "HIPAA").

C. Covered Entity and Business Associate qualify, respectively, as a "covered entity" and as a "business associate" as such terms are defined under HIPAA.

NOW THEREFORE, for good and valuable consideration, intending to be legally bound, Covered Entity and Business Associate agree as follows:

1. **Definitions.** The following terms shall have the meaning ascribed to them in this Section. Other capitalized terms shall have the meaning given such terminology by HIPAA.

    a. **Administrative, Physical and Technical Safeguards** shall have the same meaning as those terms are defined in 45 CFR 164.304.

    b. **Breach** shall mean the unauthorized acquisition, access, use, or disclosure of PHI (as defined herein) which compromises the security or privacy of such PHI.

    c. **Contract** shall refer to this document

    d. **Electronic PHI** shall have the same meaning as "electronic protected health information" in 45 CFR 160.103.

e. **HHS Privacy Regulations** shall mean the Code of Federal Regulations ("CFR") at Title 45, Sections 160 and 164, as may be amended.

f. **Individual** shall mean the person who is the subject of the Information, and has the same meaning as the term "individual" is defined by 45 CFR 160.103, including a person who qualifies as a personal representative in accordance with 45 CFR 164.502.

g. **Party or Parties** shall mean Business Associate and/or Covered Entity.

h. **PHI** shall mean information provided and/or made available by Covered Entity to Business Associate, and has the same meaning as the term "protected health information" as defined by 45 CFR 160.103.

i. **Required by Law** shall have the same meaning as the term "required by law" in 45 CFR 164.103.

j. **Secretary** shall mean the Secretary of the U.S. Department of Health and Human Services ("HHS") and any other officer or employee of HHS to whom the authority involved has been delegated.

k. **Security Incident** shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

l. **Unsecured PHI** shall have the same meaning as the term "unsecured protected health information" in 45 CFR 164.402.

2. Permitted Use or Disclosure of PHI.

a. Business Associate shall be permitted to use or disclose PHI provided or made available from Covered Entity to perform any function on behalf of Covered Entity with regard to the use and disclosure of, and/or access to, PHI that is required, necessary or desirable for Business Associate to carry out its contractual obligations set forth in the Underlying Services Agreement and/or other business responsibilities on behalf of Covered Entity provided such function would not violate HIPAA if done by Covered Entity. Business Associate may use or disclose PHI as Required by Law.

b. Except as otherwise limited in this Contract, Business Associate is permitted to use and disclose PHI received from Covered Entity if necessary for the proper management and administration of Business Associate, to carry out legal responsibilities of Business Associate, or otherwise in a manner which does not identify individual patients, provided:

i) The disclosure is Required by Law;

ii) The Business Associate obtains reasonable assurances from the person or entity to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person or entity; the person or entity will use appropriate safeguards to prevent unauthorized access to, use, or disclosure of the PHI, and the person or entity in possession of the PHI immediately notifies the Business Associate of any instance of which it is aware in which the confidentiality of the PHI has been breached; or

iii) The PHI is de-identified.

c. Business Associate shall ensure that its uses and disclosures of, and requests for PHI to or on behalf of Covered Entity, are consistent with the Minimum Necessary requirement under HIPAA and Covered Entity's Minimum Necessary policies and procedures.

d. Business Associate may use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c).

e. Business Associate may provide data aggregation services relating to the Health Care Operations of Covered Entity.

3. Business Associate's Obligations:

a. **Limits on Use and Disclosure.** Business Associate shall not use or further disclose the PHI provided or made available by Covered Entity other than as permitted or required by this Contract, or as Required by Law.

b. **Appropriate Safeguards.** Business Associate shall establish and maintain appropriate safeguards, including but not limited to those necessary for compliance with Subpart C of 45 CFR Part 164, to prevent any access to, or use or disclosure of the PHI, other than as provided for in this Contract and shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity.

c. **Education.** Business Associate shall provide HIPAA compliance education to its existing employees and all new hires who may have access to PHI.

d. **Policies and Procedures.** Business Associate shall implement reasonable and appropriate policies and procedures, as set forth in 45 CFR §164.316, to comply with the standards, implementation specifications, and/or other security requirements for the protection of Electronic PHI.

e. **Reports of Improper Use, Disclosure, Security Incident or Breach of Unsecured PHI.** Business Associate shall report to Covered Entity promptly, but no later than five (5) business days after discovery of any access to, use or disclosure of PHI not provided for or allowed by this Contract, or any Security Incident, or Breach of Unsecured PHI of which Business Associate becomes aware. (ref. 45 CFR 164.504(e)(2)(ii)(C),45 CFR 164.410 and 164.314(a)(2)(i)(C).). With respect to a Breach of Unsecured PHI, Business Associate must include the following information in its report to Covered Entity, but must not delay initial notification of the suspected Breach for purposes of collecting such information:

i) To the extent possible, the identity of each Individual whose PHI has been Breached;

ii) Brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

iii) Description of the types of Unsecured PHI that were involved in the Breach;

iv) Steps Individuals should take to protect themselves from potential harm resulting from the Breach;

v) Brief description of what Business Associate is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against further Breaches; and

f. Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.

g. **Subcontractors and Agents.** In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), anytime Business Associate's Subcontractor or agent creates, receives, maintains, or transmits the PHI on behalf of Business Associate, Business Associate shall first enter into a written agreement with the Subcontractor or agent that contains the same terms, conditions and restrictions on the access, use and disclosure of PHI as contained in this Contract. Business Associate shall also ensure that any such Subcontractor or agent to whom Business Associate provides Electronic PHI agrees in writing

to implement reasonable and appropriate safeguards to protect such Electronic PHI.

h. **Right of Access.** Business Associate shall make available PHI in a Designated Record Set to Covered Entity as necessary to satisfy Covered Entity's obligation under 45 CFR 164.524. In the event Business Associate receives a request for access to PHI directly from the Individual, Business Associate shall forward such request to Covered Entity promptly, and in no case later than five (5) business days following such request.

i. **Right to Amendment.** Business Associate shall use reasonable efforts to facilitate Covered Entity's obligation to make PHI in a Designated Records Set available for appropriate amendment by an Individual pursuant to 45 CFR 164.526. In the event Business Associate receives a request to amend such PHI directly from the Individual, Business Associate shall forward such request to Covered Entity promptly, and in no case later than five (5) business days following such request.

j. **Right to an Accounting.** Business Associate shall maintain and make available the information required to provide an accounting of disclosures of PHI to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528. In the event Business Associate receives a request for an accounting directly from the Individual, Business Associate shall forward such request to Covered Entity promptly, and in no case later than five (5) business days following such request.

k. **HIPAA Obligations.** To the extent Business Associate is to carry out one or more of Covered Entity's obligations under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of such Subpart that apply to the Covered Entity in the performance of such obligation(s).

l. **Access to Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use or disclosure of PHI received from, created, maintained or received by Business Associate on behalf of Covered Entity, available to the Secretary or the Secretary's designee for purposes of determining compliance with HIPAA.

m. **Mitigation Procedures.** Business Associate shall have procedures in place for mitigating, to the maximum extent practicable, any deleterious effect from the access, use or disclosure of PHI in a manner contrary to or inconsistent with this Contract and HIPAA.

n. **Sanction Procedures**. Business Associate shall establish and implement a system of sanctions, including documentation of the sanctions that are applied, if any, for any employee, agent or Subcontractor who violates this Contract or HIPAA.

o. **HITECH Act Compliance**. All provisions of Subtitle D of the Health Information Technology for Economic and Clinical Health Act, signed into law on February 17, 2009 ("HITECH"), that are made applicable with respect to Covered Entity shall also be applicable to Business Associate, and shall be deemed incorporated herein by reference. In accordance with HITECH and in furtherance of Business Associate's obligations set forth in this Contract, Business Associate shall:

i) Comply with sections 45 CFR 164.308; 164.310; 164.312; and 164.316 of the Security Rules.

ii) Not use or disclose PHI unless such use or disclosure is in compliance with each applicable requirement of section 45 CFR 164.504(e), provided that Business Associate shall not be in compliance with such section if it knows of a pattern of activity of the Covered Entity that is a material breach or violation of Covered Entity's obligations under this Contract, unless Business Associate takes reasonable steps to cure the breach or end the violation, as applicable, and, if such steps are unsuccessful, terminate the Contract or, if termination is not feasible, report the problem to the Secretary.

iii) Comply with the applicable minimum necessary rules established by HITECH and pursuant to any applicable regulations promulgated by the Secretary.

iv) Comply with the rules on marketing and fundraising communications established by HITECH and pursuant to any applicable regulations promulgated by the Secretary provided however, that Business Associate shall not make any such communications unless specifically authorized by the Covered Entity.

v) Comply with the rules on restrictions on certain disclosures of PHI requested by Individuals established by HITECH and pursuant to any applicable regulations promulgated by the Secretary.

vi) If Business Associate is responsible for providing an Individual access to PHI maintained in an electronic health record, provide such access in accordance with HITECH and any applicable regulations promulgated by the Secretary.

vii) Comply with the rules on accounting of disclosures of certain PHI maintained in an electronic health record (if Covered Entity uses an electronic health record) established by HITECH and pursuant to any applicable regulations promulgated by the Secretary.

viii) Comply with the rules on the sale of PHI established by HITECH and pursuant to any applicable regulations promulgated by the Secretary.

4. **Covered Entity's Obligations.**

   a. Covered Entity shall notify Business Associate of Covered Entity's Notice of Privacy Practices, including any limitation(s) in accordance with 45 CFR 164.520, to the extent the Notice of Privacy Practices and/or such limitation(s) may affect Business Associate's use or disclosure of PHI.

   b. Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

   c. Covered Entity shall notify Business Associate of any amendment or restriction to use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of the PHI.

   d. Covered entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by Covered Entity (except as set forth in 2(b) and (e) of this Contract).

5. **Property Rights.** The PHI shall be and remain the property of Covered Entity. Business Associate shall acquire no title or rights to the PHI as a result of this Contract.

6. **Independent Entities.** This Contract shall establish no relationship between the Parties other than that of independent contractors. Neither Covered Entity nor Business Associate, nor any of their respective agents or employees, shall be construed to be the agent, employee or representative of the other. None of the provisions of this Contract are intended to create, nor shall they be deemed or construed to create, any partnership, joint venture, or other relationship between the Parties except that of independent contracting entities. Business Associate acknowledges that it has independent obligations to comply with certain HIPAA requirements. Covered Entity does not make any warranties, representations or

guarantees that this Contract satisfies Business Associate's independent obligations to comply with HIPAA.

7. Term and Termination.

a. Term. The term of this Contract shall commence on the Contract Effective Date, and shall terminate upon termination of the Underlying Services Agreement (or other arrangement between the Parties), or when terminated for cause by the Covered Entity, as set forth below. Business Associate understands that termination for any reason nonetheless requires the further obligations by Business Associate set forth in section 7(c) below.

b. Termination for Cause. Covered Entity shall have the right to immediately terminate this Contract if Covered Entity determines that Business Associate (or its Subcontractor) has violated a material term of this Contract and/or HIPAA and the Business Associate (or its Subcontractor) has not taken steps to cure such material default within thirty (30) days of receipt of the Covered Entity's written notification of such material breach. However, in the event that the default cannot be cured within the 30-day cure period, the 30-day cure period shall be extended for a reasonable additional time to cure such default, provided the Business Associate commences to cure the default within the 30-day cure period and proceeds diligently to affect the cure within such reasonable additional time.

c. Effect of Termination. The obligations of Business Associate to protect the confidentiality of the PHI in its possession and/or known to it, its employees, agents or Subcontractors, shall survive termination of this Contract for any reason. In addition, at the termination of this Contract for any reason, Business Associate shall return, destroy or de-identify (so that the respective information does not identify Individuals) all PHI received from, created, maintained or received by Business Associate on behalf of Covered Entity. If return or destruction of all or part of the PHI is not commercially feasible, Business Associate shall extend the protections of this Contract for as long as necessary to protect the PHI and to limit any further access, use or disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible. If Business Associate elects to destroy the PHI it shall certify to Covered Entity in writing that the PHI has been destroyed. Destruction of PHI must be in accordance with industry standards and processes for ensuring that reconstruction, re-use and/or re-disclosure of PHI is prevented after destruction, with the exact method of destruction dependent on the media in which the PHI is contained. To the extent applicable, Business Associate shall ensure any such destruction is consistent with state and/or federal record retention laws or regulations.

8. **Change In Law/Regulation.** In the event that any new laws, regulations, or interpretations of the foregoing are promulgated, the Parties shall use reasonable efforts to promptly amend this Contract to comply with such change without any financial concession.

9. **Amendment.** This Contract may be amended by written agreement of the Parties.

10. **Choice of Law.** This Contract shall be governed by New York law and applicable federal law. The Parties also agree that for purposes of privacy rights, HIPAA shall supersede all applicable state laws, except to the extent such State laws are not preempted.

11. **Injunctive Relief.** Notwithstanding any rights or remedies provided for in this Contract, Covered Entity retains all rights to seek injunctive relief to prevent or stop the unauthorized access to, or use or disclosure of PHI by Business Associate or any agent, Subcontractor or third party that received PHI from Business Associate.

12. **Binding Nature and Assignment.** This Contract shall be binding on, and inure to the benefit of the Parties hereto and their successors and permitted assigns, but neither Party may assign this Contract without the prior written consent of the other (except to any entity controlled by, controlling or under common control with the assigning entity).

13. **Notices.** Whenever under this Contract a Party is required to give notice to the other Party, such notice shall be deemed given if mailed by First Class Certified United States mail, return receipt requested, postage prepaid or hand-delivered, including recognized overnight courier service, with confirmed receipt, and addressed as follows:

COVERED ENTITY:	BUSINESS ASSOCIATE:
CITY of ROME 198 North Washington St Rome, NY 13440	PROACT, INC. 6333 Route 298 East Syracuse, NY 13057
Attn: _____	Attn: David B. Warner

14. **Article Headings.** The article headings used are for referenced and convenience only, and shall not enter into the interpretation of this Contract.

15. **Entire Contract.** This Contract consists of this document, and constitutes the entire agreement between the Parties with respect to the subject matter herein. There are no understandings or other agreements which are not fully expressed in this Contract, and no change, waiver or discharge of obligations arising under this Contract shall be valid unless in writing and executed by the Party against whom such change, waiver

or discharge is sought to be enforced. This Contract supersedes any previous HIPAA business associate agreement between the Parties.

16. **Indemnification.** Each Party ("Indemnifying Party") shall defend, indemnify and hold the other Party harmless for any and all costs, including fines, penalties, interest and reasonable attorneys' fees, related to any claim, liability, suit, or investigation by law enforcement or other governmental or regulatory agency or brought by an Individual related to the wrongful acts or omissions of the Indemnifying Party, its employees, agents or subcontractors, whether intentional or negligent, that violates the HHS Privacy Regulations regarding access to, use of or disclosure of PHI.

IN WITNESS WHEREOF, Covered Entity and Business Associate have caused this Contract to be signed and delivered by their duly authorized representatives, as of the date first set forth above.

PROACT, INC.	**CITY of ROME**
_____	_____
BY	BY
David B. Warner	_____
NAME	NAME
President	_____
TITLE	TITLE
_____	_____
DATE	DATE

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 63

AUTHORIZING THE MAYOR TO ENTER INTO AN AGREEMENT WITH AN AUDITING FIRM OR CERTIFIED PUBLIC ACCOUNTANT FOR 2015

By _____:

WHEREAS, Section 93 Title A of the City Charter Laws provides that the Board of Estimate and Contract shall enter into an agreement for each fiscal year with a certified public accountant or firm of accountants for a continuous audit of the City's financial operations for such year; now, therefore,

BE IT RESOLVED, that the City of Rome shall enter into an agreement with the firm of D'Arcangelo & Co. for the year 2015 in the amount of $69,900.00, pursuant to their attached proposal which is made part of this Resolution; and

BE IT FURTHER RESOLVED, that the Mayor is authorized to execute the necessary agreement.

Seconded by _____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

D'Arcangelo & Co., LLP
Certified Public Accountants & Consultants

200 E. Garden St., P.O. Box 4300, Rome, N.Y. 13442-4300
315-336-9220 Fax: 315-336-0836

January 26, 2015

Mr. Joseph R. Fusco, Jr., Mayor and
Mr. John Mazzaferro, President of the Common Council
City of Rome
City Hall
Rome, NY 13440

Dear Mayor Fusco:

We are pleased to confirm our understanding of the services we are to provide City of Rome, New York for the year ended December 31, 2014.

We will audit the financial statements of the governmental activities, the business-type activities, the aggregate discretely presented component units, each major fund, and the aggregate remaining fund information, including the related notes to the financial statements, which collectively comprise the basic financial statements, of City of Rome, New York as of and for the year ended December 31, 2014. Accounting standards generally accepted in the United States of America provide for certain required supplementary information (RSI), such as management's discussion and analysis (MD&A), to supplement City of Rome, New York's basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to City of Rome, New York's RSI in accordance with auditing standards generally accepted in the United States of America. These limited procedures will consist of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We will not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance. The following RSI is required by generally accepted accounting principles and will be subjected to certain limited procedures, but will not be audited:

- Management's Discussion and Analysis.
- Schedule of Funding Progress of the Other Postemployment Benefits
- Schedules of Revenues, Expenditures, and Other Financing Sources (Uses) Budget and Actual

We have also been engaged to report on supplementary information other than RSI that accompanies City of Rome, New York's financial statements. We will subject the following supplementary information to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America and will provide an opinion on it in relation to the financial statements as a whole:

- Schedule of Expenditures of Federal Awards
- Combining Balance Sheet – General Fund
- Combining Revenues, Expenditures, and Other Financing Sources (Uses) – General Fund
- Schedule of State Transportation Assistance Expended, if required.

In addition to our audit, we will also provide the additional following services:

1. Type and provide bound copies of the annual report of the City of Rome, New York.
2. Continuous audit of claims and payroll in accordance with Article VII, Section 93 of the Charter for the City of Rome, New York.
3. We are available during the year for reasonable consultation services.
4. Apply agreed-upon procedures for the monthly financial statements of the City of Rome, New York, as made available, in accordance with standards established by the American Institute of Certified Public Accountants.
5. Apply agreed-upon procedures for the annual budget of the City of Rome, New York.
6. We will assist in the preparation of the New York State Annual Update Document as prescribed by the New York State Office of the State Comptroller.

Audit Objectives

The objective of our audit is the expression of opinions as to whether your basic financial statements are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles and to report on the fairness of the supplementary information referred to in the second paragraph when considered in relation to the financial statements as a whole. The objective also includes reporting on—

- Internal control related to the financial statements and compliance with the provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a material effect on the financial statements in accordance with *Government Auditing Standards*.
- Internal control related to major programs and an opinion (or disclaimer of opinion) on compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a direct and material effect on each major program in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

The Government Auditing Standards report on internal control over financial reporting and on compliance and other matters will include a paragraph that states (1) that the purpose of the report is solely to describe the scope of testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance, and (2) that the report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the entity's internal control and compliance. The OMB Circular A-133 report on internal control over compliance will include a paragraph that states that the purpose of the report on internal control over compliance is solely to describe the scope of testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Both reports will state that the report is not suitable for any other purpose.

Our audit will be conducted in accordance with auditing standards generally accepted in the United States of America; the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the provisions of OMB Circular A-133, and will include tests of accounting records, a determination of major program(s) in accordance with OMB Circular A-133, and other procedures we consider necessary to enable us to express such opinions. We will issue written reports upon completion of our Single Audit. Our reports will be addressed to the Common Council of the City of Rome, New York. We will make reference to Toski and Co., PC's audit of Rome Housing Authority in our report on your financial statements. We cannot provide assurance that unmodified opinions will be expressed. Circumstances may arise in which it is necessary for us to modify our opinions or add emphasis of matter or other matter paragraphs. If our opinions on the financial statements or the Single Audit compliance opinions are other than (unmodified), we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed opinions, we may decline to express opinions or to issue reports, or may withdraw from this engagement.

Management Responsibilities

Management is responsible for the financial statements, NYS Annual Update Document, schedule of expenditures of federal awards, and all accompanying information as well as all representations contained therein. Management is also responsible for identifying all federal awards received and understanding and complying with the compliance requirements, and for preparation of the schedule of expenditures of federal awards (including notes and noncash assistance received) in accordance with the requirements of OMB Circular A-133. As part of the audit, we will assist with preparation of your financial statements, schedule of expenditures of federal awards, and related notes. These nonaudit services do not constitute an audit under Government Auditing Standards and such services will not be conducted in accordance with Government Auditing Standards. You agree to assume all management responsibilities relating to the financial statements, schedule of expenditures of federal awards, related notes, and any other nonaudit services we provide. You will be required to acknowledge in the management representation letter our assistance with preparation of the financial statements, schedule of expenditures of federal awards, and related notes and that you have reviewed and approved the financial statements, schedule of expenditures of federal awards, and related notes prior to their issuance and have accepted responsibility for them. Further, you agree to oversee the nonaudit services by designating an individual, preferably from senior management, who possesses suitable skill, knowledge, or experience; evaluate the adequacy and results of those services; and accept responsibility for them.

Management is responsible for (a) establishing and maintaining effective internal controls, including internal controls over compliance, and for evaluating and monitoring ongoing activities, to help ensure that appropriate goals and objectives are met; (b) following laws and regulations; (c) ensuring that there is reasonable assurance that government programs are administered in compliance with compliance requirements; and (d) ensuring that management is reliable and financial information is reliable and properly reported. Management is also responsible for implementing systems designed to achieve compliance with applicable laws, regulations, contracts, and grant agreements. You are also responsible for the selection and application of accounting principles; for the preparation and fair presentation of the financial statements in conformity with U.S. generally accepted accounting principles; and for compliance with applicable laws and regulations and the provisions of contracts and grant agreements.

Management is also responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, (2) additional information that we may request for the purpose of the audit, and (3) unrestricted access to persons within the government from whom we determine it necessary to obtain audit evidence.

Your responsibilities also include identifying significant vendor relationships in which the vendor has responsibility for program compliance and for the accuracy and completeness of that information. Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the written representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the government involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the government received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the entity complies with applicable laws, regulations, contracts, agreements, and grants. Management is also responsible for taking timely and appropriate steps to remedy fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, or abuse that we report. Additionally, as required by OMB Circular A-133, it is management's responsibility to follow up and take corrective action on reported audit findings and to prepare a summary schedule of prior audit findings and a corrective action plan. The summary schedule of prior audit findings should be available for our review on the first day of our fieldwork.

You are responsible for preparation of the schedule of expenditures of federal awards (including notes and noncash assistance received) in conformity with OMB Circular A-133. You agree to include our report on the schedule of expenditures of federal awards in any document that contains and indicates that we have reported on the schedule of expenditures of federal awards. You also agree to include the audited financial statements with any presentation of the schedule of expenditures of federal awards that includes our report thereon or make the audited financial statements readily available to intended users of the schedule of expenditures of federal awards no later than the date the schedule of expenditures of federal awards is issued with our report thereon. Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the schedule of expenditures of federal awards in accordance with OMB Circular A-133; (2) that you believe the schedule of expenditures of federal awards, including its form and content, is fairly presented in accordance with OMB Circular A-133; (3) that the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the schedule of expenditures of federal awards.

You are also responsible for the preparation of the other supplementary information, which we have been engaged to report on, in conformity with U.S. generally accepted accounting principles. You agree to include our report on the supplementary information in any document that contains and indicates that we have reported on the supplementary information. You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon or make the audited financial statements readily available to users of the supplementary information no later than the date the supplementary information is issued

with our report thereon. Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the supplementary information in accordance with GAAP; (2) that you believe the supplementary information, including its form and content, is fairly presented in accordance with GAAP; (3) that the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the supplementary information.

Management is responsible for establishing and maintaining a process for tracking the status of audit findings and recommendations. Management is also responsible for identifying for us previous financial audits, attestation engagements, performance audits, or other studies related to the objectives discussed in the Audit Objectives section of this letter. This responsibility includes relaying to us corrective actions taken to address significant findings and recommendations resulting from those audits, attestation engagements, performance audits, or studies. You are also responsible for providing management's views on our current findings, conclusions, and recommendations, as well as your planned corrective actions, for the report, and for the timing and format for providing that information.

With regard to the electronic dissemination of audited financial statements, including financial statements published electronically on your website, you understand that electronic sites are a means to distribute information and, therefore, we are not required to read the information contained in these sites or to consider the consistency of other information in the electronic site with the original document.

Audit Procedures—General

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity. Because the determination of abuse is subjective, *Government Auditing Standards* do not expect auditors to provide reasonable assurance of detecting abuse.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is a risk that material misstatements or noncompliance may exist and not be detected by us, even though the audit is properly planned and performed in accordance with U.S. generally accepted auditing standards and *Government Auditing Standards*. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements or major programs. However, we will inform the appropriate level of management of any material errors, any fraudulent financial reporting, or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential, and of any material abuse that comes to our attention. We will include such matters in the reports required for a Single Audit. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, and may include direct confirmation of receivables and certain other assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We will request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from you about your responsibilities for the financial statements; schedule of expenditures of federal awards; federal award programs; compliance with laws, regulations, contracts, and grant agreements; and other responsibilities required by generally accepted auditing standards.

Audit Procedures—Internal Controls

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*.

As required by OMB Circular A-133, we will perform tests of controls over compliance to evaluate the effectiveness of the design and operation of controls that we consider relevant to preventing or detecting material noncompliance with compliance requirements applicable to each major federal award program. However, our tests will be less in scope than would be necessary to render an opinion on those controls and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to OMB Circular A-133.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards, *Government Auditing Standards*, and OMB Circular A-133.

Audit Procedures—Compliance

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of City of Rome, New York's compliance with provisions of applicable laws, regulations, contracts, and agreements, including grant agreements. However, the objective of those procedures will not be to provide an opinion on overall compliance and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards*.

OMB Circular A-133 requires that we also plan and perform the audit to obtain reasonable assurance about whether the auditee has complied with applicable laws and regulations and the provisions of contracts and grant agreements applicable to major programs. Our procedures will consist of tests of transactions and other applicable procedures described in the *OMB Circular A-133 Compliance Supplement* for the types of compliance requirements that could have a direct and material effect on each of City of Rome, New York's major programs. The purpose of these procedures will be to express an opinion on City of Rome, New York's compliance with requirements applicable to each of its major programs in our report on compliance issued pursuant to OMB Circular A-133.

Engagement Administration, Fees, and Other

We understand that your employees will prepare all cash, accounts receivable, or other confirmations we request and will locate any documents selected by us for testing.

At the conclusion of the engagement, we will complete the appropriate sections of the Data Collection Form that summarizes our audit findings. It is management's responsibility to submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditors' reports, and corrective action plan) along with the Data Collection Form to the federal audit clearinghouse. We will coordinate with you the electronic submission and certification. If applicable, we will provide copies of our report for you to include with the reporting package you will submit to pass-through entities. The Data Collection Form and the reporting package must be submitted within the earlier of 30 days after receipt of the auditors' reports or nine months after the end of the audit period, unless a longer period is agreed to in advance by the cognizant or oversight agency for audits.

The audit documentation for this engagement is the property of D'Arcangelo & Co., LLP and constitutes confidential information. However, subject to applicable laws and regulations, audit documentation and appropriate individuals will be made available upon request and in a timely manner to New York Office of the State Comptroller or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. We will notify you of any such request. If requested, access to such audit documentation will be provided under the supervision of D'Arcangelo & Co., LLP personnel. Furthermore, upon request, we may provide copies of selected audit documentation to the aforementioned parties. These parties may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

The audit documentation for this engagement will be retained for a minimum of seven years after the report release date or for any additional period requested by an oversight agency for audit or pass-through entity. If we are aware that a federal awarding agency, pass-through entity, or auditee is contesting an audit finding, we will contact the party (ies) contesting the audit finding for guidance prior to destroying the audit documentation.

Leonard Carissimo, CPA, is the engagement partner and is responsible for supervising the engagement and signing the reports or authorizing another individual to sign them.

The fees for our audit services to the City of Rome, New York, for 2015 will be $69,900. This does not include the fee for the preparation of the New York State annual report. The billings for our audit fees will be $5,200 monthly. The monthly fee can be allocated by charging $4,200 to the General City Fund, $500 to the Water fund, and $500 to the Sewer fund. We will also bill $7,500 in June for Community Development.

In addition, if needed we will assist in the preparation of the New York State annual report and bill separately for the service at our standard rates, which are not expected to exceed $5,500.

If significant, additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs.

D'Arcangelo & Co., LLP
Certified Public Accountants & Consultants

We will be available during the year for consultation on various accounting matters. Our fee for such services will be at standard rates and will be discussed with you at that time. Our standard rates are:

Partner	$ 150
Manager	$ 90
Senior	$ 70

Government Auditing Standards require that we provide you with a copy of our most recent external peer review report and any letter of comment, and any subsequent peer review reports and letters of comment received during the period of the contract. Our 2010 peer review report accompanies this letter.

We appreciate the opportunity to be of service to City of Rome, New York and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please sign the enclosed copy and return it to us.

Very truly yours,

D'Arcangelo + Co., LLP

Enclosures

D'Arcangelo & Co., LLP:

This letter correctly sets forth the understanding of City of Rome.

Joseph R. Fusco, Jr. — Mayor
Joseph R. Fusco, Jr. — Title

John J. Mazzaferro — President of the Common Council
John Mazzaferro — Title

SYSTEM REVIEW REPORT

To the Partners of D'Arcangelo & Co., LLP
and the National Peer Review Committee

We have reviewed the system of quality control for the accounting and auditing practice of D'Arcangelo & Co., LLP (the firm) applicable to non-SEC issuers in effect for the year ended September 30, 2013. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants. As a part of our peer review, we considered reviews by regulatory entities, if applicable, in determining the nature and extent of our procedures. The firm is responsible for designing a system of quality control and complying with it to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Our responsibility is to express an opinion on the design of the system of quality control and the firm's compliance therewith based on our review. The nature, objectives, scope, limitations of, and the procedures performed in a System Review are described in the standards at www.aicpa.org/prsummary.

As required by the standards, engagements selected for review included engagements performed under *Government Auditing Standards* and audits of employee benefit plans.

In our opinion, the system of quality control for the accounting and auditing practice of D'Arcangelo & Co., LLP applicable to non-SEC issuers in effect for the year ended September 30, 2013, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of *pass*, *pass with deficiencies* or *fail*. D'Arcangelo & Co., LLP has received a peer review rating of *pass*.

Smith Elliott Kearns & Company, LLC

Hagerstown, Maryland
November 21, 2013

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 64

AUTHORIZING THE MAYOR OF THE CITY OF ROME TOENTER INTO AN AGREEMENT WITH WAGEWORKS, INC. (AN AFFILIATE OF AFLAC)

By _____;

WHEREAS, David C. Nolan, Treasurer, for the City of Rome, has recommended that the City of Rome, New York, retain the services of Wage Works, Inc. (an affiliate of AFLAC; now, therefore,

BE IT RESOLVED, by the Board of Estimate and Contract of the City of Rome, that the Mayor of the City of Rome is hereby authorized to enter into an agreement with Wage Works, Inc. (an affiliate of AFLAC), for services described more specifically in the attached agreement, which is made part of this Resolution.

Seconded by _____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

Aflac®

Dear **DAVID NOLAN**:

Thank you for choosing Aflac's Flex One® flexible benefits plan. We appreciate your business.

Enclosed is a packet containing the documents necessary to establish a cafeteria plan with the assistance of Flex One. Please carefully review the Flexible Benefits Plan Document and Summary Plan Description (SPD), and verify that all of the information about benefits offered, eligibility, plan administration, and funding is correct.

Please notice that the sample Flexible Benefits Plan Document refers to the Summary Plan Description with regard to many of the plan's provisions. This approach eases administration and reduces the risk of inconsistency between the Flexible Benefits Plan Document provisions and the Summary Plan Description provisions. For example, if you have changes in the plan, most of the plan changes will only require formal adoption by the governing body of the employer and distribution of a Summary of Material Modifications (discussed in more detail below). You should also note that these documents are only sample documents typical of a plan intended to qualify as a Section 125 Cafeteria Plan with the terms and conditions thereof, and that they may need to be modified to conform to your individual circumstances.

Aflac has developed these documents with legal counsel, and it is Aflac's intent and belief that the documents in form satisfy the requirements of IRS Code Section 125. However, Aflac is not in the business of offering legal counsel or tax advice, and thus, Aflac cannot and does not make any representations about the legal or tax effect of these documents upon any particular employer. Therefore, it is each employer's responsibility to determine, with the assistance of the employer's own legal counsel, the suitability of these particular documents, and the legal and tax effect of these plan documents upon the employer and its employees.

Since Aflac has no control over your subsequent modification and/or administration of the plan and since the Internal Revenue Service will not render an opinion as to a plan's qualified status under IRS Code Section 125, Aflac makes no representation (express or implied) as to your plan's qualification under IRS Code Section 125 and related provisions as adopted and subsequently amended by you.

You, as sponsoring employer, bear sole responsibility for amending your plan (as necessary) to comply with existing tax law and future changes, for meeting all reporting and disclosure requirements imposed by applicable law, and for the daily administration of your plan. As such, we recommend you review the following important information:

Important Compliance Issues

Nondiscrimination Testing. This test is at the very core of the legal requirements imposed by Section 125 of the Internal Revenue Code. Failure to satisfy these requirements will cause adverse tax consequences to highly compensated and/or key employees and could possibly disqualify the plan. For details regarding your nondiscrimination testing requirements, please refer to the Flex One Account Establishment Information Checklist.

Qualified Premiums. Certain insurance premiums that cover the employee (or in the case of accident or health coverage other than life insurance, the employee and tax dependents/family) may be included in the Flexible Benefits Plan Documents if adopted as part of your benefits plan. These include the following:

- Group Term Life Insurance covering the employee (eligible under IRS Code Section 79) that is equal to or less than $50,000 (Life insurance coverage on dependents is not eligible for pre-tax treatment.)
- Accidental-Death and Dismemberment (AD&D) coverage
- Medical, dental, hospital indemnity, cancer insurance, vision, hearing, and other qualified accident and health premiums

Effects on taxes. When including health, medical, and disability income policies within the Flexible Benefits Plan, paying for coverage on a pre-tax basis may cause insurance benefit payments under medical coverage to be subject to federal and state taxes if benefit payments from all medical policies/plans are in excess of actual medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable.

Continuation of Coverage. Health benefits offered through a cafeteria plan may be subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). See the SPD for more details.

Continuation of Coverage During FMLA Leave. Health benefits (including health FSA benefits) and nonhealth benefits offered through a cafeteria plan are subject to the continuation and reinstatement provisions of the Family and Medical Leave Act of 1993 ("FMLA"). See Question 13 of the SPD for more details on coverage offered under the Plan during FMLA leave.

FLEX ONE® ACCOUNT ESTABLISHMENT INFORMATION AND CHECKLIST

Important steps for establishing your Flex One account

➢ **For all Flex One Cafeteria Plans:**

☐ **Employer's Acknowledgment:** After executing and adopting your Plan Document, please sign and date the Employer's Acknowledgment in order to officially adopt and execute your plan. Place the signed and dated Employer's Acknowledgment in your files with a copy of your Plan Document Packet.

☐ **Summary Plan Description:** A copy must be provided to each eligible employee as soon as possible. Regulations require distribution within 120 days of the effective date of the initial plan year and within 90 days of the effective date of coverage for all subsequent plan years.

➢ **For all Flex One plans with FSAs when Flex One is the claims processor:**

To ensure that your account is established in a timely manner, the following documents must be returned to Flex One **at least 10 working days prior to the effective date of your plan.** You may return these documents by toll-free fax to (877) FLEX-SRA (877-353-9772) or by mail to Aflac Benefit Services/Flex One, 1932 Wynnton Road, Columbus, GA 31999-9950.

☐ **Salary Redirection Agreements (SRAs):** Completed SRAs for all Flexible Spending Account (FSA) participants must be returned to Flex One.

☐ **Reimbursement Services Agreement (RSA):** The RSA must be signed in the second signature block and returned to Flex One. It will be signed by Flex One and returned to you for your records.

Important information for administering your Flex One account

☐ **Plan Identification Number (PIN):** The Department of Labor regulations require that welfare benefit plan sponsors assign a three-digit PIN number to their welfare plans (including cafeteria plans) for identification purposes. Numbering for welfare plans should begin at 501 and proceed consecutively. If you have other plans (e.g., health coverage) assign the next open number. This number must be indicated on the Summary Plan Description.

☐ **Affiliated Companies:** Only those companies described in Section 414(b), (c) or (m) of the Internal Revenue Code can participate in a cafeteria plan. In addition, if there are affiliated companies, nondiscrimination testing may be affected by affiliated companies. Consult your tax advisor.

☐ **5500 and Summary Annual Report:** There is no Form 5500 filing requirement for the cafeteria plan itself. IRS Notice 2002-24 suspended this requirement. Please note that Notice 2002-24 does not affect annual reporting requirements under ERISA. Thus, welfare benefit plans subject to ERISA, which may include Health Flexible Spending Accounts (FSAs), must continue to file Form 5500 and any applicable schedules (unless an applicable exception applies) even if the benefits are funded through the cafeteria plan. You should contact your tax or legal advisor to find out if your Plan is subject to ERISA and whether filing a Form 5500 (including any applicable schedules) for your Plan is required.

☐ **Nondiscrimination Testing:** Tax nondiscrimination tests, including the Eligibility, Contributions and Benefits, and Concentration of Benefits tests, must be performed. In the case of Flexible Spending Accounts (FSAs), nondiscrimination tests must be performed for each FSA. Upon request, Aflac Benefit Services will assist you at no extra charge with the Cafeteria Plan Key Employee 25% Concentration Test, Dependent Care 55% Average Benefit Test, and Dependent Care 5% Shareholder Test.

☐ **Health FSAs:** You, as Plan Sponsor, are responsible for ensuring that the Health FSA maximum, is in line with your risk tolerance/ Remember IRS Notice 2005-42 allows an additional 2 ½ month period (i.e., grace period) in which to incur additional medical expenses. If you have selected the grace period feature, the Aflac sample plan incorporates this extension for Health FSAs.

☐ **Eligibility:** Any eligibility waiting period for pre-tax benefits should generally be uniformly applied. You, as Plan Sponsor, are responsible for ensuring that the eligibility period listed in your plan documents does not violate Internal Revenue Service or Department of Labor regulations.

☐ **Privacy:** You, as Plan Sponsor, are responsible for ensuring that your plan does not violate the privacy requirements set forth in the Gramm-Leach-Bliley Act of 1999 (GLB) and, if applicable, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). GLB regulates the privacy of financial information and applies to all Flex One plans (see the attached "Privacy Practices"). HIPAA protects privacy by regulating the disclosure of protected health information (PHI), so Plan Sponsors of only Health FSAs must comply with HIPAA privacy requirements (Health FSA Plan Sponsors only, see the attached "Important Privacy Information").

*** If you have any questions regarding this checklist, please contact Flex One toll-free at (877) FLEX-IVR (877-353-9487), and one of our Customer Service Representatives can assist you Monday through Friday from 8:00 A.M. to 7:00 P.M. EST.**

Employer Acknowledgment: Your signature verifies that an Aflac sales representative has reviewed the above information with you.

Signature _____ Printed Name _____ Date _____

GLB PRIVACY PRACTICES

Protecting the privacy and confidentiality of employer and participant information through our Cafeteria Plan Services is very important to American Family Life Assurance Company of Columbus (Aflac) and American Family Life Assurance Company of New York (Aflac New York). Throughout this notice when we use the name "Aflac," we will be referring to both organizations. Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information about employers or employees of an employer for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.

- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of the employer and employees of the employer are properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.

- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that its employees and agents carry out these practices and otherwise protect the personal information. Both employees and agents are subject to censure, dismissal or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

PRIVACY NOTICE

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

Collection of Information

As part of Aflac's normal operating procedures, Aflac (and our agents acting on our behalf) need to obtain information from both the employer and the participant to service the flexible spending accounts. Aflac and our agents may collect nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about Aflac customers, including but not limited to:

- Information from the employer or the participant (including names, addresses, Social Security numbers, financial and marital status, and health and dependent child-care information);

- Information about the employer or the participants' transactions with Aflac or our agents (including claims, payment information and banking information);

- Information from the employer or the participants' health care providers (including drug receipts and medical information), employers (including benefit elections and employment information) and family members.

Disclosure of Information

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your election amounts, premiums, and payment history) to our agents or other third parties who perform services for us or functions on our behalf, including the marketing of Aflac services. Aflac may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of the employer or the participants' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make.

Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about our customers for any purpose other than the servicing of the employer's flexible spending account plan by Aflac or on our behalf, or to which the customer consents.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

SUMMARY OF HIPAA AND SECURITY PRIVACY RULES

I. Introduction

The HIPAA Privacy and Security rules regulate the use and disclosure of protected health information (PHI) by defining who is authorized to access PHI created, transmitted or held by covered entities and for what purposes.

A. Who is Covered

There are four types of covered entities under HIPAA: health plans (which includes Health FSAs), health care clearinghouses, Medicare prescription drug card sponsors, and health care providers if they transmit certain standard transactions electronically. Employers that are not in the health care services field normally are not covered entities. Nevertheless, employers, as health plan sponsors, must agree to comply with certain privacy requirements if they want to receive PHI from their health plans.

B. Basic Concepts

Health plan sponsors should understand and recognize the following basic concepts under the Privacy and Security Rules: (1) what is PHI; (2) which plans are considered health plans under the Privacy rules; and (3) what is a business associate.

1. PHI

PHI is individually identifiable health information in any form, including oral, written and electronic, that is held, created, or transmitted by a covered entity. Individually identifiable health information is health information that relates to an individual's past, present, or future physical or mental health or condition, or to the provision of health care to that person, or to the past, present, or future payment for that person's health care; and that identifies the individual. Some common identifiers are name, address, birth date and Social Security number. Examples of PHI held, created, or maintained by health plans include claims information and claims payment history.

2. Health Plans

A health plan is defined in the Privacy rules as an individual or group plan that provides (or pays the cost of) medical care. In addition to Health FSAs, this definition includes virtually all arrangements that pay the cost of medical care, including group health plans, health insurers, Medicare and Medicaid.

Some plans that may provide health care are excluded from the definition of a health plan under HIPAA. These include accident-only plans, disability plans, liability insurance plans, workers' compensation programs and on-site medical clinics. Aslo, self-administered and self-funded health plans that have fewer than 50 participants may be exempt. Note that this exclusion does not apply to a self-funded health plan that uses a third-party administrator.

3. Business Associates

Service providers who receive or create PHI to assist health plans in connection with their health care functions are considered business associates under the HIPAA Privacy and Security Rules. Examples of business associates are third party administrators (TPAs), consultants, insurance agents and brokers, claim auditors, and utilization review companies. Employees of the Plan Sponsor and the Plan Sponsor itself are *not* business associates.

Business associates normally are not covered entities themselves under HIPAA. However, before a health plan may disclose PHI to a business associate, the HIPAA Privacy and Security Rules require the plan (through its Plan Sponsor) to enter into a contract (called a business associate agreement) with the business associate. This contract legally obligates the business associate to agree to restrictions on the use and disclosure of PHI. (*We have attached our "HIPAA Business Associate Agreement" as Exhibit A. It is intended to satisfy your HIPAA privacy and security business associate requirements with respect to Aflac's flexible spending account services.*)

II. How the Privacy Rules Affect Sponsors of Self-Insured Health Plans

As mentioned above, Plan Sponsors are not covered entities under HIPAA. Nevertheless, if you are a Plan Sponsor of a self-insured plan, the Privacy Rules impose requirements on both you and your plan. These include the following:

- provide individuals with the rights to access and amend PHI and to receive an accounting of certain PHI disclosures (as described in Section II.A below);
- prepare and provide a privacy notice (as described in Section II.B below); and
- comply with the administrative safeguards applicable to covered entities (as described in Section II.C below).

PHI for any employment purpose without the individual's authorization. A health plan may not condition treatment or payment on an authorization, except in very limited circumstances.

The Privacy Rules also require covered entities to make reasonable efforts to use, disclose and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure or request. For example, a health plan cannot request an entire medical record, if it only needs information regarding an office visit for a particular day. The minimum necessary requirement does not apply in the following instances: (1) disclosures for treatment by a health care provider; (2) disclosure to individuals about their own PHI; (3) uses or disclosures made pursuant to authorization; and (4) uses or disclosures required by law.

B. Individual Rights and Privacy Notice

The Privacy Rules grant individuals certain rights with respect to their health information. Such rights include the ability to access and amend their PHI maintained by the Plan and receive a privacy notice. As Plan Sponsor, you need to coordinate with your TPA and any other business associates to satisfy these requirements. In response to any participant inquiries that you receive, Aflac will make available any PHI that it maintains for your URM/Health FSA plan.

1. Individual Rights

- An individual has the right to inspect and copy his or her own PHI.
- An individual has the right to request an amendment or correction to any of his or her PHI that is inaccurate or incomplete.
- An individual also has the right to obtain an accounting of disclosure other than those made for treatment, payment or health care operations

2. Privacy Notice

The health plan is required to provide a notice of privacy practices for PHI to all individuals enrolled in the health plan. This notice must describe the uses and disclosures of PHI that may be made by the covered entity, the individual's rights, and the covered entity's legal duties with respect to the PHI. The Privacy notices must be provided to individuals at the time of an individual's enrollment in the plan and within 60 days after a material change to the notice. In addition, plans must provide a notice of availability of the privacy notice at least once every three years.

It is likely that you will be sending out Privacy Notices for other health plans that you sponsor where you have access to PHI. If this is the case, you might consider combining the Privacy Notices for plans where the information (e.g., who has access to PHI) is the same. If you do not otherwise have a Privacy Notice obligation, you must prepare and distribute a Privacy Notice for your Health FSA. *(For your convenience, we have attached a sample privacy notice as Appendix II to the Flexible Benefits Plan Summary Plan Description (SPD). Review the sample notice with your legal advisor and make any necessary changes before distributing it to your employees as it will govern participant rights under the Privacy Rules.)*

C. Administrative Safeguards for the Privacy Rules

In implementing the administrative safeguard requirements, the Plan Sponsor must evaluate the roles of its employees to determine which employees (or classes of employees) will have access to PHI. The Plan Sponsor must then implement policies and procedures to ensure that only these designated employees (or classes of employees) have access to PHI, and even then, only to the minimum amount of PHI necessary to perform plan administration duties for the health plan. For example, PHI from the health plan may not be used to administer the disability program, which is not considered a health plan under the privacy rule. Finally, the Plan Sponsor must ensure that these employees do not use or disclose PHI in a way prohibited by the final regulations. If you sponsor other health plans and have access to PHI you likely will have already begun to establish your HIPAA Policies and Procedures document.

A Plan Sponsor of a self-insured plan must satisfy the following administrative safeguard requirements:

- Designate a privacy official responsible for the development and implementation of policies and procedures;
- Designate a contact person or office for receiving complaints and providing additional information concerning the privacy notice (this may be but is not required to be the same person as the privacy official);
- Train all employees who will have access to PHI on privacy policies and procedures;
- Establish appropriate administrative safeguards (both technical and physical) to protect PHI from accidentally being used or disclosed in violation of HIPAA's requirements (for example, all PHI should be kept in locked file cabinets and computer systems should have adequate firewalls to protect electronically stored PHI);

Exhibit A

HIPAA
BUSINESS ASSOCIATE AGREEMENT

THIS APPENDIX, effective _____ by and between American Family Life Assurance Company of Columbus (Aflac) and the CITY OF ROME, NEW YORK MEDICAL CARE REIMBURSEMENT PLAN (the "URM Plan") is adopted by the CITY OF ROME, NEW YORK (the "Employer") on behalf of the URM Plan and is incorporated into and made a part of the Reimbursement Services Agreement ("Agreement") between Aflac and the Employer. This Exhibit A is intended to comply with the business associate agreement provisions set forth in 45 CFR §§ 164.314 and 164.504(e), and any other applicable provisions of 45 CFR parts 160 and 164, issued pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 as amended, including by the Health Information Technology for Economic & Clinical Health Act of the American Recovery and Reinvestment Act of 2009 ("ARRA"), (collectively "HIPAA").

Aflac recognizes that in the performance of services for the URM Plan under the Agreement it will have access to, create, and/or receive from the URM Plan or on its behalf Protected Health Information ("PHI"). For purposes herein, PHI shall have the meaning given to such term in 45 CFR § 1640.103, limited to the information created or received from the URM Plan or on its behalf by Aflac. Whenever used in this Exhibit A other capitalized terms shall have the respective meaning set forth below, unless a different meaning shall be clearly required by the context. In addition, other capitalized terms used in this Exhibit A but not defined herein, shall have the same meaning as those terms are defined under HIPAA.

SECTION 1. AFLAC RESPONSIBILITIES

1.1 Aflac may use or disclose PHI, provided that such use or disclosure of PHI would not violate HIPAA, as follows: (a) as permitted or required in this Exhibit A and in the Agreement; (b) as Required by Law in accordance with 45 CFR § 164.512; (c) for the proper management and administration of Aflac; (d) to fulfill any present or future legal responsibilities; (e) for Data Aggregation services to the URM Plan (as defined in 45 CFR § 164.501); or (f) any use and disclosure of PHI that has been de-identified within the meaning of 45 CFR § 164.514.

1.2 Aflac agrees to implement commercially reasonable and appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Exhibit A.

1.3 Aflac agrees to implement commercially reasonable administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the URM Plan.

1.4 Aflac agrees to report to the URM Plan any successful Security Incident that is material or any use or disclosure of PHI of which it becomes aware that is not provided for by this Exhibit A or in the Agreement.

1.5 Aflac agrees to ensure that any agent, including a subcontractor, to whom it provides PHI agrees to similar restrictions and conditions that apply through this Exhibit A to Aflac with respect to such information.

1.6 At the request of the URM Plan, and in a mutually agreeable time and manner, Aflac agrees to provide access to PHI it holds in a Designated Record Set (as defined in 45 CFR § 164.501), to the URM Plan, or as directed by the URM Plan, to an Individual in order to meet the requirements under 45 CFR § 164.524. Aflac shall have the right to charge the Individual a reasonable cost-based fee, as permitted by 45 CFR § 164.524. Aflac assumes no obligation to coordinate the provision of PHI maintained by other business associates of the URM Plan.

1.7 At the request of the URM Plan, and in a mutually agreeable time and manner, Aflac agrees to make any amendment(s) to PHI it holds in a Designated Record Set that the URM Plan directs or agrees to pursuant to 45 CFR § 164.526 at the request of the URM Plan or an Individual.

1.8 At the request of the URM Plan, and in a mutually agreeable time and manner, Aflac agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Aflac on behalf of the URM Plan available to the Secretary (as defined in 45 CFR § 160.103), for purposes of the Secretary determining the URM Plan's compliance with the Privacy and Security Rules.

1.9 Aflac agrees to document such disclosures of PHI and information related to such disclosures as would be required for the URM Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

1.10 Aflac agrees to provide to URM Plan or an Individual, in the time and manner designated by URM Plan, information collected in accordance with 1.09 to permit the URM Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

3.3 Both parties acknowledge that future changes to the requirements of HIPAA, the Privacy and Security Rules, and other applicable laws relating to the security or confidentiality of PHI may require amendment of this Exhibit A. Upon the written request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Exhibit A. If either party disagrees with any such amendment, it shall so notify the other party in writing within 30 days of notice. If the parties are unable to agree on an amendment within 30 days thereafter, then any of the parties may terminate the Agreement in accordance with the termination section of the Agreement.

3.4 Notwithstanding Section 3.3 above and without limiting the rights of the parties under the Agreement, upon written notice of the existence of an alleged material breach of the terms of this Exhibit A, the URM Plan shall afford Aflac an opportunity to cure said breach upon mutually agreeable terms. Failure to cure within 30 days shall be immediate grounds for termination of the Agreement.

3.5 Section 1.11 shall survive the termination or expiration of the Agreement for the reasons stated therein. The other provisions of this Exhibit A shall survive the termination of the Agreement and remain in full force and effect thereafter for so long as Aflac or any of its employees, agents or subcontractors remains in possession of PHI in accordance with Section 1.11 of this Exhibit A and shall expire thereafter.

IN WITNESS WHEREOF, the parties hereto have caused this Exhibit A to the Reimbursement Services Agreement to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to do so.

Dated at Aflac this _____ day of _____

By: _____
Jason A. Goodroe
Second Vice President, Aflac Benefit Services

Dated at _____ this _____ day of _____

By: _____

Street Address: _____

_____

_____

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FLEXIBLE BENEFITS PLAN

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.14 **"Eligible Medical Expenses"** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the URM and during the Plan Year (plus any applicable grace period extension as described in the SPD) to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d): i) expenses for qualified long term care services (as defined in Code § 7702B(c)); and ii) expenses incurred for health insurance premiums. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.15 **"Employee"** means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes. Such term includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer. The term "Employee" shall not include any leased employee (as that term is defined in Code Section 414(n)) or any self- employed individual who receives from the Employer "net earnings from self-employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee.

1.16 **"Employer"** means the Employer and the Affiliated Employers named in the SPD provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only that entity named on the first line of the Plan Information Summary of the SPD, and not any Affiliated Employer. Affiliated Employers who sign the Plan Information Summary and/or otherwise adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

1.17 **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.18 **"Health Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.19 **"Highly Compensated Individual"** means an individual defined under Code Section 105(h), 125(e), or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.20 **"Key Employee"** means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.21 **"Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Benefit Plan(s) or Policy(ies) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Plans or Policies offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

1.22 **"Participant"** means an Employee who becomes a Participant pursuant to Article II.

1.23 **"Plan"** means the Flexible Benefits Plan, the SPD (defined in Section 1.35 herein) and (if applicable) the related Trust created by this document.

1.24 **"Plan Administrator"** means the person(s) or Committee identified in the SPD that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.25 **"Plan Year"** shall be the period of coverage set forth in the SPD (as extended by any applicable grace period as set forth in the SPD).

1.26 **"Pre-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Salary Redirection Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan or Policy afforded hereunder, and for

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03 Eligibility to Participate in Reimbursement Accounts. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Reimbursement Accounts, if adopted by the Employer, on the date set forth in the SPD. Participation in the Reimbursement Accounts shall be effective on the date set forth in the SPD.

2.04 Qualifying Leave Under FMLA. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Plans or Policies that provide health coverage (including URM benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave, and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.05 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III - BENEFIT ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (as set forth in the SPD) to fund any Benefit Plan or Policy available under the Plan, provided that only Qualified Benefits may be funded with Pre-tax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Plans or Policies offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Nonelective Contributions among the various Benefit Plans or Policies in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file an SRA with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial SRA shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period**. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a SRA with the Plan Administrator (or its designated third party administrator as set forth on the SRA) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Plans or Policies will be effective in accordance with the governing provisions of such Benefit Plans or Policies.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a SRA in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date that the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.04 Change of Elections. A Participant shall not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Nonelective Contributions except for election changes permitted under this Section 3.04, and for changes made during the Annual Election Period (Section 3.03), changes caused by termination of employment (Section 3.05) and changes pursuant to the Family and Medical Leave Act (Section 2.04).

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the

ARTICLE V - BENEFITS

5.01 Qualified Benefits. The maximum benefit a Participant may elect under this Plan shall not exceed the sum of i) the aggregate premium for all Benefit Plan(s) or Policy(ies) set forth in the SPD (other than Health and DDC); ii) the maximum annual Health Care Reimbursement under the URM as set forth in the SPD (if offered under the Plan); and iii) the maximum annual Dependent Care Reimbursement under the DDC as set forth in the SPD (if offered under the Plan).

(a) **Special Rules for Health Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Spouse or Dependents while he is a Participant during the Plan Year (plus any grace period extension as specified in the SPD) for which the Participant's election is effective provided that the substantiation requirements of Section 6.05 herein are satisfied.

(b) **Special Rules for Dependent Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year (plus any applicable grace period extension as described in the SPD) for which the Participant's election is effective, provided that the substantiation requirements of Section 6.05 have been satisfied.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

5.03 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.05 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 Termination of Reimbursement Accounts. Coverage under the URM and/or DDC shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however, that Participants may submit claims for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time until the end of the Run-Off period set forth in the SPD. Participants in the URM may submit claims for reimbursement for Eligible Medical Expenses arising during the Plan Year and before the date of separation from service at any time until the end of the Run-Off period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Sections 4.03 or 4.04. A special grace period may be applicable with regard to URM and/or DDC participation after the close of the Plan Year (see SPD).

5.05 Coordination of Benefits Under the URM. The URM is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VI - PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. In the case of an insured Benefit Plan or Policy, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03 below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g. by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided in Section 4.03 and 4.04 herein.

ARTICLE X - GENERAL PROVISIONS

10.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

10.03 Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 Nonalienation of Benefits. Except as expressly provided by the Plan Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

10.05 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.06 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

10.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 Source of Payments. The Employer, the Trust fund (if selected as Funding Agent), and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon

IN WITNESS WHEREOF, the Employer has executed this Plan as of the date set forth below.

EMPLOYER'S ACKNOWLEDGMENT

As evidenced by the formal execution of this document, the undersigned Employer adopted and established this Plan on the Effective Date as the Flexible Benefits Plan of the undersigned Employer. In doing so, the undersigned Employer acknowledges that the Summary Plan Description ("SPD") and this Plan document are important legal instruments with significant legal and tax implications.

The Employer also acknowledges that it has read this SPD and the Plan document in their entirety, has consulted independent legal and tax counsel other than representatives of American Family Life Assurance Company of Columbus (Aflac), to the extent considered necessary, and accepts full responsibility for participation of Employees hereunder and the operation of the Plan. The Employer acknowledges that, as sponsor and Plan Administrator, it shall have sole responsibility to comply with all filing, reporting, and disclosure requirements imposed by the DOL, IRS, or any other government agency, specifically including, but not limited to, creating and filing Form 5500s and preparing and distributing SPDs and performing required nondiscrimination testing. Furthermore, the Employer further acknowledges that it shall bear sole responsibility for amending the Plan as necessary to ensure compliance with applicable tax, labor, and other laws and regulations. The Employer acknowledges receipt of the checklist of Plan Sponsor Responsibilities included provided with the applicable plan document request form and has agreed to the obligations set forth therein..

It is also understood and agreed that American Family Life Assurance Company of Columbus (Aflac), and its subsidiaries, agents, and representatives, are not providing legal or tax advice to the undersigned Employer in connection with this Plan and that no representations are made by it with respect to the operation of the Flexible Benefits Plan pursuant to the documents provided by American Family Life Assurance Company of Columbus (Aflac) to the Employer.

This Plan shall be construed and enforced according to the Internal Revenue Code of 1986, as amended from time to time, the applicable regulations thereto, and the laws of the state of the principal place of business of the Employer.

IN WITNESS WHEREOF, the Employer has caused this Plan and Summary Plan Description to be executed on the day of _____,_____ to ratify the adoption of the Plan adopted and effective as of the Effective Date.

WITNESS:

Corporate Officer

Employer: City of Rome

By: _____

Title: _____

Date: _____

ATTACHMENT I - SUMMARY PLAN DESCRIPTION

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the SRA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

[**X**] Medical Coverage

[**X**] Vision Care Coverage

[**X**] Disability Income - Short Term (A&S)

[**X**] Cancer Insurance

[**X**] Dental Coverage

[**X**] Group Term Life Insurance

[ ] Disability Income - Long Term (LTD)

[ ] Intensive Care Insurance

[**X**] Accident Insurance

[**X**] Hospital Indemnity Insurance (HIP)

[ ] Specified Health Event

[ ] Personal Sickness Indemnity (PSI)

[**X**] Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed $ **3000** per Plan Year pursuant to the **CITY OF ROME, NEW YORK** Medical Care Expense Reimbursement Plan.

should be 2550.00

Name and Address of Medical Care Expense Reimbursement Plan
COBRA Administrator (if applicable): _____

_____

_____

[**X**] Dependent Care Expense Reimbursement described in Appendix I to this SPD, not to exceed $5,000 per Plan Year or $2,500 for married filing separate returns pursuant to the **CITY OF ROME, NEW YORK** Dependent Care Expense Reimbursement Plan.

[ ] Health Savings Account (as defined in Code Section 223) established with the following

Custodian/Trustee: _____

[ ] Opt-out Option: See Employer enrollment material.

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one):

❑ The Employer, which will comply with the requirements of Article VII of the Plan.

❑ The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan.

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

❑ The Employer, except as otherwise noted in the Plan.

❑ The Participants, except as otherwise noted in the Plan.

Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

Q-5. How do I become a Participant?

You become a Participant by signing an individual Salary Redirection Agreement ("SRA") on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided an SRA when you first become eligible to participate in this Plan. You must complete the form and turn it in to the Personnel Office during the applicable enrollment period described in Q-6 below.

Q-6. What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the "Initial Enrollment Period" or the "Annual Enrollment Period". You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called "Default Benefits" and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file an SRA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting an SRA prior to the beginning of each Plan Year -- no deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	Without Cafeteria Plan
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Monthly Savings: $31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the SRA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or

and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Plan Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

  Example: Employee Mike is married to Sharon, and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Benefit Plan or Policy for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

   Effective April 1, 2009, if you or your eligible Dependent (1) lose coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) lose coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) become eligible for group health plan premium assistance under Medicaid or SCHIP and you are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependent(s) because of medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, you may be eligible to elect medical coverage under a Benefit Plan or Policy for yourself and your Dependent(s). You must request an election change to enroll in group plan coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan or (2) the Employee or dependent child is determined eligible for state premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

Q-13. What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary.

Q-4. When does coverage under the URM and/or DDC end?

You continue to participate in the URM and/or DDC until the ealier of (i) you elect not to participate in accordance with Q-9 of Flexible Benefits Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period; (iii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iv) you terminate employment with the employer; or

(v) the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You are not eligible to receive reimbursement for otherwise Eligible Medical Expenses incurred during the Plan Year after you cease to be eligible unless you elect COBRA continuation coverage (as described below in Q-18 of this Appendix), provided you are eligible to elect COBRA. However, you will be eligible to receive reimbursement under the DDC for Eligible Employment-Related Expenses (as defined in Q-9 below) incurred during the Plan Year but after you cease to be eligible up to your account balance as of the date you cease to be eligible.

Coverage under the URM for your Eligible Dependents ends on earliest of the following to occur: (i) your coverage ends; (ii) the individual ceases to be an Eligible Dependent (e.g. divorce or legal separation from the spouse); or (iii) the Plan is terminated or amended to exclude individual or the class of individuals of which the individual is a member (spouse or dependent child) from coverage under the URM. Your Spouse and/or your Dependent children may also be entitled to COBRA continuation coverage if coverage is lost for certain reasons. See Q-18 of this Appendix for more information on COBRA.

Q-5. What happens to my URM Account and/or DDC Account if I take an approved leave of absence?

Generally, the rules described in Q-13 of your Flexible Benefits Plan SPD apply. However, if your URM coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the URM at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a URM reimbursement level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your URM coverage was not in effect are not eligible for reimbursement under this URM.

Q-6. What is the maximum URM and/or DDC benefit I may elect?

For URM, you may choose any amount of annual reimbursement you desire subject to the maximum reimbursement amount set forth in the Employer Information Section of the Plan Information Summary.

For DDC, this is set forth in the Employer Information Section, however, this amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently $5,000 per Plan Year if you -

- are married and file a joint return; or
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DDC, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes.

If you are married and reside together but file a separate federal income tax return, the maximum DDC benefit you may elect is $2,500.

You will be required to pay the annual contribution equal to the coverage level you have chosen.

Q-7. How is my Medical Care and/or Dependent Care Expense Reimbursement benefit paid for and what amounts will be available at any particular time during the Plan Year?

For URM and DDC, when you complete the SRA, you specify the amount of Medical Care and or Dependent Care Expense Reimbursement(s) you wish to pay for with your Pre-tax Contributions. Thereafter, you must make a contribution for such coverage by having an equal portion of the annual reimbursement amount deducted from each paycheck. Your employer will distribute benefit payments from its general assets.

For URM Benefits, the full amount of the coverage you have elected, reduced by the amount of prior reimbursements received during the Plan Year, will be available to reimburse you for your out-of-pocket medical expenses incurred at any time during the Plan Year and while you are a Participant. For DDC Benefits, the amount that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Account less any reimbursements already paid.

For DDC, you may be reimbursed for work-related expenses ("Eligible Employment-Related Expenses") incurred on behalf of any Qualifying Individual described below. Generally, these expenses must meet all of the following conditions for them to be Eligible Employment-Related Expenses:

- The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies.

- Services are incurred for a Qualifying Individual. A Qualifying Individual is:

  1. An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g., a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her own support; or

  2. A Spouse or other tax "Dependent" (as defined generally in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" means an individual who is your tax dependent as defined under Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Section 151(d); (ii) the individual is a dependent of a Participant who is a tax dependent of another taxpayer under Code Section 152 or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

- The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.

- If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

- If the expenses are incurred for services provided by a Dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:

1. $5,000

2. $2,500, if you are married but you and your Spouse file separate tax returns.

3. Your taxable compensation (after your Pre-tax Contributions have been deducted under the Plan).

4. If you are married, your Spouse's actual or deemed Earned Income.

5. For purposes of (4.) above, your Spouse will be deemed to have Earned Income of $250 ($500 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself or (ii) a full-time Student.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-10. When must the expenses be incurred?

Eligible Medical and Employment-Related Expenses must generally have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before your SRA becomes effective, or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage and certain Eligible

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical and/or Employment-Related Expense was incurred shall be forfeited.

Q-17. What happens if a Claim for Benefits under the URM or DDC is denied?

You will be notified if your claim under the Plan is denied. The notice will be furnished to you as soon as reasonably possible but no later than 30 days after the Plan Administrator (or its designated claims administrator identified in the reimbursement form) receives your claim. However, if for reasons beyond the control of the claims reviewer, more time for processing your claim is needed, the applicable claims reviewer may take an extension of not more than 15 days following the end of the 30-day period. You will be notified of this extension before the initial 30 days has expired, and the notice will explain why an extension is necessary and the date a decision is expected to be rendered. If the reason for the extension is because you failed to submit complete information necessary to decide the claim, you will have 45 days from the notice of the extension in which to provide the information. The time period for making a decision will be suspended until the earlier of the date that you submit the necessary information or the end of the 45-day period.

The notice of the denial will include the following:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claim to be approved and an explanation of why such material or information is necessary;
- instructions on how to appeal the denied claim (including the applicable time periods) and the identity of the individual(s) who will review the denied claim; and
- Any other information required by applicable law.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time described in the notice of denial in which to request a second review by the Plan Administrator. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. You will be notified in writing of the decision on review as soon as reasonably possible but no later than 60 days after the request for review is received. The notice will contain the same type of information described above and it will indicate whether there are one or two levels of appeals. If there are two levels of appeals, the decisions on review will be made no later than 30 days after the request for each review is received. The reviews upon appeal (whether one level or two) will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in a previous review. In no event will a determination upon review be made by the same individual(s) who made previous determinations or someone who is a subordinate of any individual who made such previous determinations. The Plan Administrator is the claims fiduciary responsible for making final claim decisions under the Plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-18. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the URM only, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

<u>When Coverage May Be Continued</u>

If you are a Participant in the URM, then you have a right to choose continuation coverage under the URM if you lose your coverage because of a reduction in your hours of employment; or a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage due to the death of your Spouse; a voluntary or involuntary termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment; or the divorce or legal separation from your Spouse.

- After you elect COBRA continuation coverage, the date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation;
- After you elect COBRA continuation coverage, the date that you first become entitled to Medicare; or
- The date the employer no longer provides group health coverage to any of its employees.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the URM and DDC indefinitely, it has the right to modify or terminate the programs at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-20. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the URM and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. Attached as Appendix II to this SPD (included in the HIPAA packet) is a summary of your rights and obligation under HIPAA. You may receive a separate notice that outlines the Employer's health privacy policies in more detail.

Q-21. Is there any other important information that I should know about the Reimbursement Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name has also been provided in the Plan Information Summary.

ERISA Rights

The URM may be an ERISA welfare benefit plan (unless the employer is a governmental employer or the plan is a "church plan" as defined in the applicable regulations). As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage. You should review Q-19 of this appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the URM is subject to HIPAA's portability rules:) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

APPENDIX II TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Summary of URM HIPAA Privacy Policies and Procedures

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the URM claims reimbursed under the Plan for Plan administration purposes. This summary applies to all of the medical records we maintain with regard to the URM. Your personal doctor or health care provider will have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. During the course of providing you with health coverage under the URM, the Plan will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. In accordance with Section 10.18 of the Plan, the following is a summary of procedures adopted by the Employer to ensure that both Employer and any third party service providers treat your PHI with the level of protection required by HIPAA. You may receive a separate notice that provides more detailed information regarding the procedures adopted by Employer.

This summary will provide you with a general overview of the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. **In the event this summary conflicts with the separate Privacy Notice from Employer, the separate Privacy Notice controls.**

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. Except as otherwise provided in the separate Privacy Notice that may be provided to you, these employees consist of the members of the Personnel Benefits Department of Employer who assist in administration of URM claims. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

By adoption of the SPD, Employer has certified that it will comply with the privacy procedures summarized herein and detailed in any separate privacy notice. Employer may not use or disclose your PHI other than as summarized herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information for purposes of URM administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan administrative operations. These uses and disclosures are necessary to run the Plan.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. You will be notified of where you can obtain an accounting of disclosure in the separate Privacy Notice. Your request must state a time period that may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Personnel Office except as otherwise provided in the separate Privacy Notice. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this summary and the separate Privacy Notice that may be provided to you. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Personnel Office except as otherwise provided in the separate Privacy Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

BOARD OF ESTIMATE AND CONTRACT FEBRUARY 26, 2015

RESOLUTION NO. 65

AUTHORIZING AN EXTENSION OF AN AGREEMENT WITH R&S COMPLETE TEXTILE (ROBISON & SMITH, INC.) TO PROVIDE PROFESSIONAL LINEN/LAUNDY SERVICES FOR CITY OF ROME FIRE DEPARTMENT

By _____:

WHEREAS, the Board of Estimate and Contract of the City of Rome, New York, by Resolution No. 216 adopted September 26, 2013, authorized the Mayor of the City of Rome to enter into an agreement with R&S Complete Textile (Robison & Smith, Inc.), of Rome, New York, for professional laundry services for the Rome Fire Department for a term beginning November 14, 2013 through November 14, 2014, which included the option of one two-year extension; and

WHEREAS, Donna Piekarski, Purchasing Agent for the City of Rome, has advised the Board of Estimate and Contract that it would be in the City's best interests to extend the original contract for an additional two-year period; now, therefore,

BE IT RESOLVED, that the Mayor of the City of Rome, New York, is hereby authorized to extend the contract for two (2) years, with R & S Complete Textile Service (Robison & Smith), for professional laundry services for the Rome Fire Department, at a total amount not to exceed $2,000.00 which shall include a 5% discounted rate, pursuant to their attached proposal which is made part of this Resolution.

Seconded by _____.

AYES & NAYS: Mayor Fusco ____ Mazzaferro ____ Tallarino ____
Benedict ____ Nolan ____

ADOPTED: DEFEATED:

ROBISON & SMITH
Linen. Uniforms. Image.

RENEWAL AGREEMENT

Robison & Smith, Inc.
(Hereafter referred to as COMPANY or "R&S")

Date: 1/27/15
Rep: B. Vincent
Route: 96 Day: Tue

CUSTOMER INFORMATION: (Hereafter referred to as CUSTOMER)

Account #: 0146701
Account/Company Name: City of Rome Fire Dept.
Main Contact: _____ Title: _____

Updated phone or email?
Phone: (_____) _____
Email: _____ **O** Email Invoices

SERVICE/DELIVERY ADDRESS:

_____
_____
_____

NEW! Customer Portal!
Sign up to access and pay online at
www.robison-smith.com/portal

BILLING ADDRESS:
(if update required)

_____
_____
_____

THIS RENEWAL AGREEMENT REFERS TO SERVICES AND ITEMS ON YOUR PREVIOUS AGREEMENT AND INVOICES, AND EXTENDS THE TERM FOR THOSE SERVICES, AND ANY ADDITIONAL LINEN, UNIFORM, AND TEXTILE SERVICES TAKEN BY CUSTOMER.

PRICING: The pricing reflected on the most recent invoice to Customer dated previous to this agreement WILL BE DISCOUNTED BY FIVE PERCENT (5.0%) UPON SIGNING OF THIS AGREEMENT.

Customer acknowledges that the LinenCare and WearCare Maintenance Programs **have been offered to them**, and if declined, the Customer is responsible to pay the full replacement value of any damaged or missing linen and/or garments deemed not at fault of R&S, at the discretion of R&S, through the use of soil counts and/or of RFID tracking.
ENROLL in LinenCare? Y / N **ENROLL in WearCare? Y / N**

CUSTOMER agrees to take from R&S exclusively during the term of the Agreement all of the Customer's requirements in the customer's business for the supply of clean laundered articles. Additional textile rental services required by the Customer shall be at the Company's usual service charges at the time of installation and subject to the terms hereof. All textile rental services used by the Customer, or such other items which may be required by the Customer at the later date during of this Agreement, shall be supplied exclusively by the Company. The Customer acknowledges that because of the nature of the textile rental business, the damages be difficult, if not impossible, to determine. Therefore, in the event of Customer breach, the Customer shall pay to the Company liquidated damages as explained on the reverse of this agreement. In the event of any premature termination of this Agreement, the Customer is responsible for purchasing from the Company any merchandise that was bought specifically for servicing the Customer.

THIS AGREEMENT IS SUBJECT TO ALL OF THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE HEREOF, ALL OF WHICH ARE INCORPORATED IN AND MADE PART OF THIS AGREEMENT.

SIGNATURE OF PARTIES: __Corporation __Individual __Partnership __Govt. Agency

_____
Print Customer/Company Name

Brian Vincent PSR 725.4841
Print R&S Representative Name/Title

_____
Print Name/Title of Customer Contact

Brian Vincent
Signature of R&S Representative

_____ _____
Signature of Authorized Customer Contact Date

_____ _____
Approved By (R&S RSM/VP) Date